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Volume 167 Number 1 January 1985

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Illinois State Medical Society

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For many years, medical society members in the state of Illinois have been subject to the "unified membership" provision of the ISMS bylaws. That requirement stipulates that in order to be a member of a component society—county, ISMS, and/or AMA, a member must be a member of all three. Unified membership began in 1950. Prior to that time, contributions from the component state societies plus advertising revenue supported the AMA, and state society members were automatically AMA members without payment of dues. When dues to the AMA became necessary, the ISMS House of Delegates amended the bylaws to include unified membership and so we are at present.

Earlier in these pages I noted that we physicians need a rational organization to address national and federal level problems and that, especially now, if we did not have such an organization, we would have to invent one.

Despite the obvious advantages of membership in a national body, some members found compulsory membership in the AMA (or, conversely, state/county membership requisite for the AMA) distasteful, either because of philosophical differences or the lack of freedom of choice. We have seen their numbers—both individual members and delegates—increase over the past several years.

The majority of your elected leadership has been in favor of continued unified membership. Recently, however, due in no small part to membership desires, we studied the advantages and disadvantages thereof. We also asked the AMA officers and Board of Trustees if they valued our unified status. When they answered in the affirmative, we asked them to "show us." They have.

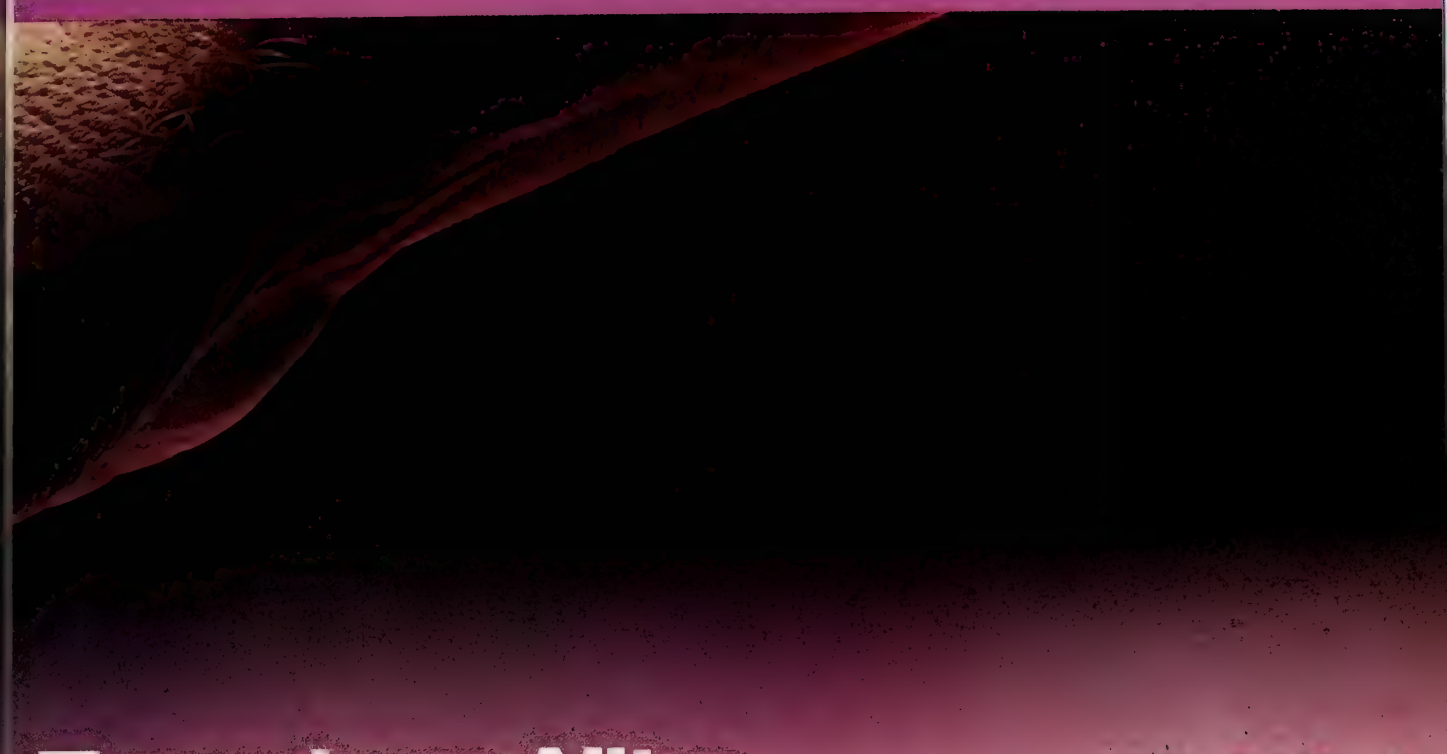
Last July, at the annual meeting of the AMA, we were awarded two extra delegates, thus giving us additional national representation. After continuing study, the AMA Board presented Report DD to the House at its December interim meeting. It passed and is now AMA policy.

This report has several recommendations, the most palpable of which is that unified state members will receive a 10% rebate of their 1985 and subsequent dues. Other concessions include improved access to the AMA and some other financial considerations.

I believe that we *all* need the AMA; they have demonstrated that they need us. It's a two-way street. ◀

Robert C. Hamilton, M.D.
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born to stay
on better
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Contraindicated in patients with intolerance to organic nitrate drugs.

All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA. (See Brief Summary of Prescribing Information on the next page.)

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(nitroglycerin)
Transdermal Therapeutic System

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)*

INDICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

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Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

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In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.

In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.

Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.

Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

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Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.

Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea, vomiting, and dermatitis. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.

The usual dosage is one Transderm-Nitro 5 system every 24 hours. Some patients, however, may require the Transderm-Nitro 10 system. If a single Transderm-Nitro 5 system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 systems or one Transderm-Nitro 10 system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone.

The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs

Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

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5 mg/24 hr	25 mg	10 cm^2	7 Systems (NDC 0083-2105-07)
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Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

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ABSTRACTS OF ACTIONS

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

November 9, 1984

Clock Tower Inn
Rockford, Illinois

AMICUS CURIAE BRIEF

In a recent action, *Ahmed v. Cook County Hospital, et al.,* Cook County Judge Kowalski, subsequent to rendering an award in favor of the plaintiffs, directed an award for pre-judgment interest on both pecuniary and non-pecuniary damages calculated from the date of injury. The Board believed that this action was improper since it lacked statutory authority. Legal Counsel recommended that ISMS seek leave of the court to file an *amicus curiae* brief advocating reversal of the award of pre-judgment interest. The Board authorized filing an *amicus curiae* brief in the matter of *Ahmed v. Cook County Hospital et al.,* challenging the award of pre-judgment interest.

HOLD HARMLESS

Over the past several years, the Society has studied the issue of "hold harmless" letters sent to patients by third party payors. The typical "hold harmless" letter informs the patient that insurance pays only the "reasonable charge" and the third party payor will pay cost of legal defense and indemnification should the patient choose not to pay the balance of the physician's bill and subsequently face legal action. There is great concern with allowing this practice to continue. The Board directed that legal counsel, as appropriate, meet with a major Illinois employer who is presently engaged in this activity, and seek redress on the issue of "hold harmless" letters.

HOSPITAL MEDICAL STAFFS

The Board considered two items regarding hospital medical staffs. First, medical staff bylaws covering acute emergency situations, and second, the need to clarify JCAH standards regarding medical staff membership for limited license practitioners.

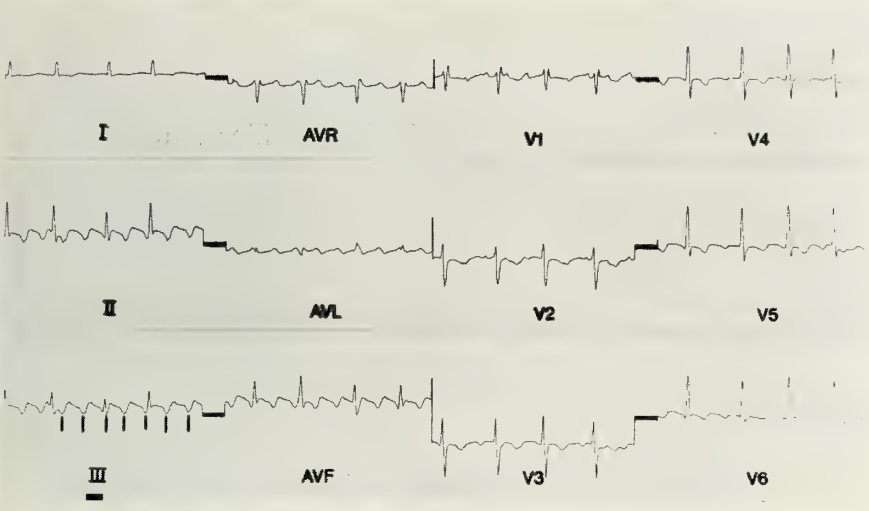
The Board directed that the Society: (A) Communicate to Illinois hospital medical staffs the importance of a review of bylaws and hospital policies which unduly restrict physicians from responding appropriately in life-threatening situations, with further research referred to the Council on Medical Services for study and report at the January Board meeting; and (B) Provide information to hospital medical staffs which has been published by the JCAH regarding medical staff membership for limited license practitioners.

(Continued on page 64)

EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This patient is a 59 year old woman who gave an 18 month history of gradually worsening dyspnea on exertion. She also complained of severe fatigue and some ankle swelling. She had recently received digoxin and some diuretic medication, but these did not seem to help. Physical examination showed a blood pressure of 120/42mmHg, an irregularly irregular pulse, and bibasilar crepitant rales in the lung bases. The heart had an increased P_2 and an opening snap of the mitral valve with a diastolic rumble murmur at the apex. She had pitting pretibial edema to the knees bilaterally. An admission blood count showed a hemoglobin of 5.3gms%, hematocrit 15, and MCV 120 cubic microns. An echocardiogram was compatible with mitral valve disease, a markedly enlarged left atrium, and a pericardial effusion. Selected blood tests showed normal folate and B-12 levels, and slightly increased serum iron, reticulocyte count, and serum bilirubin. Some ventricular ectopy was seen following a surgical procedure and was treated. This twelve lead ECG was recorded afterward.



Questions:

1. **The twelve lead ECG shows:**
 a. Atrial fibrillation.
 b. Digitalis intoxication.
 c. Atrial flutter.
 d. Right ventricular hypertrophy.
 e. Left ventricular hypertrophy.

2. **Management of this patient could include:**
 a. Packed red blood cell transfusions.
 b. Cardiac catheterization.
 c. Bone marrow aspiration or biopsy.
 d. Permanent demand pacemaker.
 e. Long term intravenous antibiotics.

(Continued on page 48)

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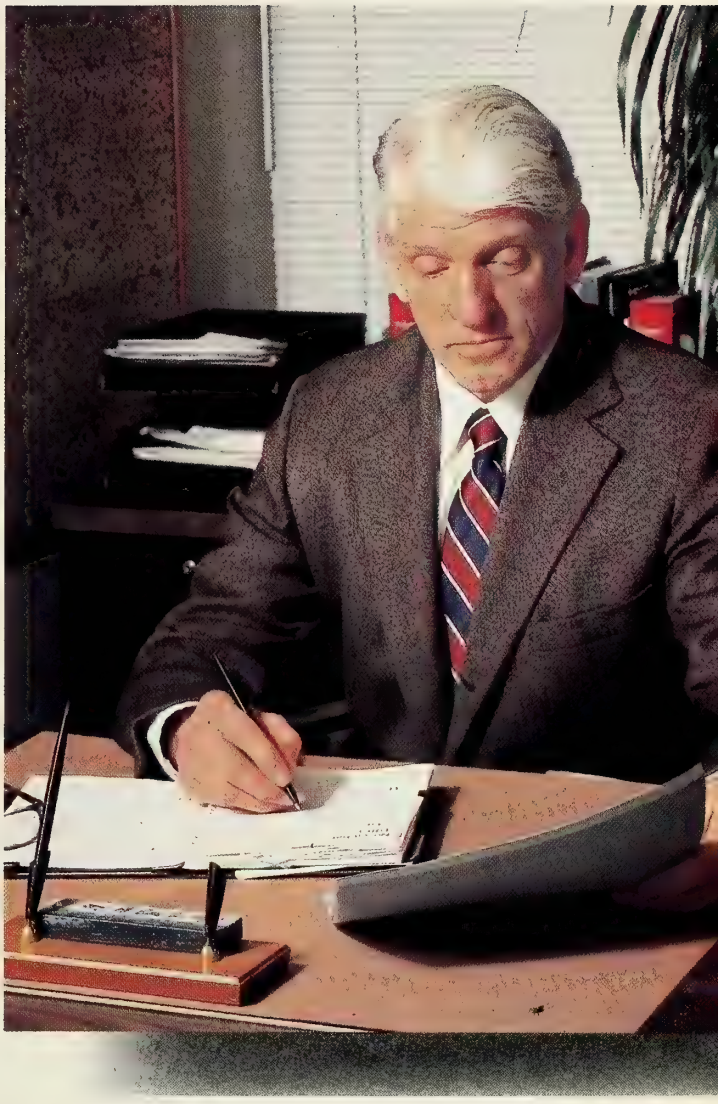
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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided, with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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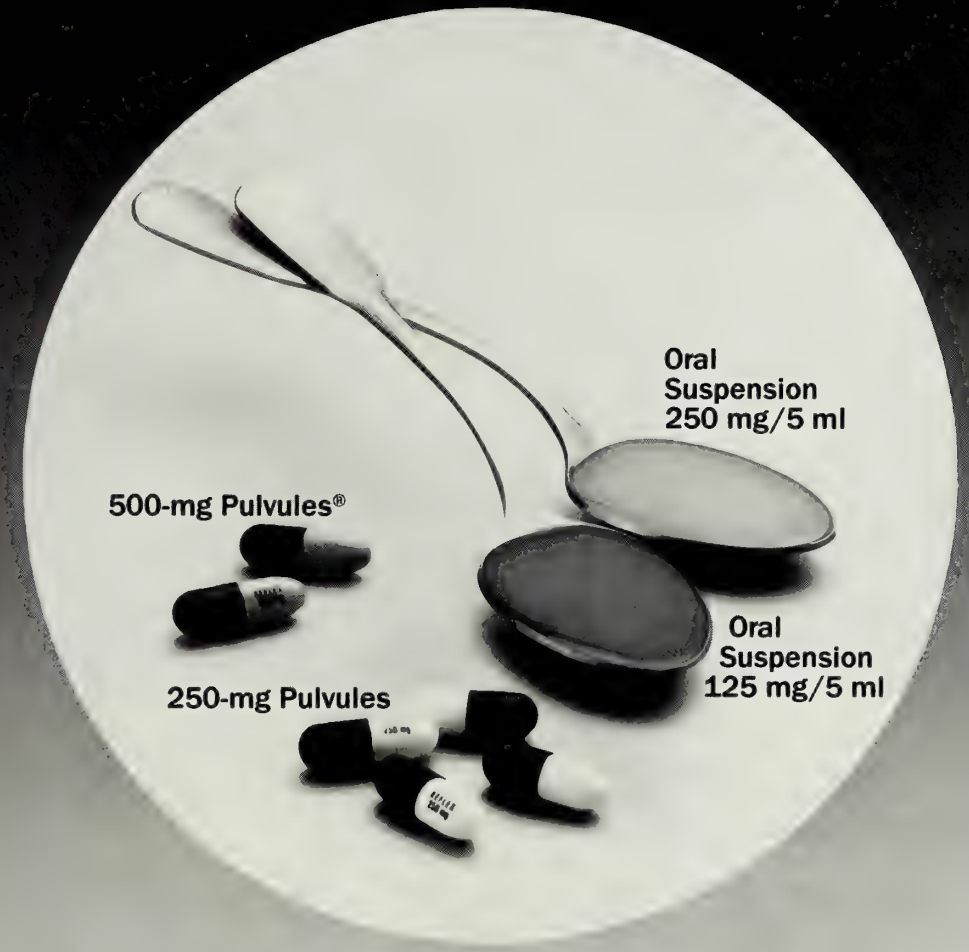
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Action Teams

The Professional Liability Initiative organized by the Illinois State Medical Society and the Illinois State Medical Inter-Insurance Exchange is in full swing, with physicians forming "action teams" in their hospitals and county medical societies.



Dr. Merrill Reiss

Action teams are the mechanism developed by ISMS and the Exchange to encourage legislators to pass remedial legislation proposed by ISMS. Hospital action teams are being organized to include physicians, hospital administrators, members of hospital governing boards, representatives of allied health professions and members of hospital auxiliaries. In some areas, teams are being formed around county medical societies.

Meetings between legislators and local hospital medical staffs to discuss the malpractice problem are an initial goal of the action team program. These early meetings are to be followed by continuing contact with legislators through telephone calls and letters.

To date, some 82 action teams are under development across the state. The first was organized by Dr. Merrill Reiss, president of the medical staff at Alexian Brothers Hospital in Elk Grove Village. Besides contacting legislators and meeting with hospital boards and medical staffs, the energetic Dr. Reiss has helped form teams at other hospitals, testified before legislative committees, volunteered to speak to a variety of groups about the problem, and brought legislators to meet with hospital boards.

Another part of the action team effort involves coordinating appearances by physicians before lay audiences and meetings with local media representatives. To help physicians clearly communicate the magnitude of the problem and explain the proposed solutions to lay groups, ISMS has developed a brief audiovisual presentation and a host of printed material.

Many physicians have made appearances before business and civic groups; an estimated 4,800 people had seen the malpractice slide show through the end of December. Requests for the slide show have been increasing steadily, and showings are scheduled as far in advance as March.

A Hinsdale pathologist, Dr. Erlo Roth, has been instrumental in generating media interest in the malpractice issue. Dr. Roth's letter to the editor of the *Chicago Sun-Times* resulted in assignment of a reporter to develop a news story on the ISMS/ISMIE legislative proposals.

Action teams also are being asked to coordinate communication with the legal community. Not all attorneys are trial lawyers, and support for legal reforms can be found among attorneys who serve as counsel to hospitals and physicians. Action teams may be able to encourage these attorneys to write their legislators in support of the ISMS/ISMIE legislation.

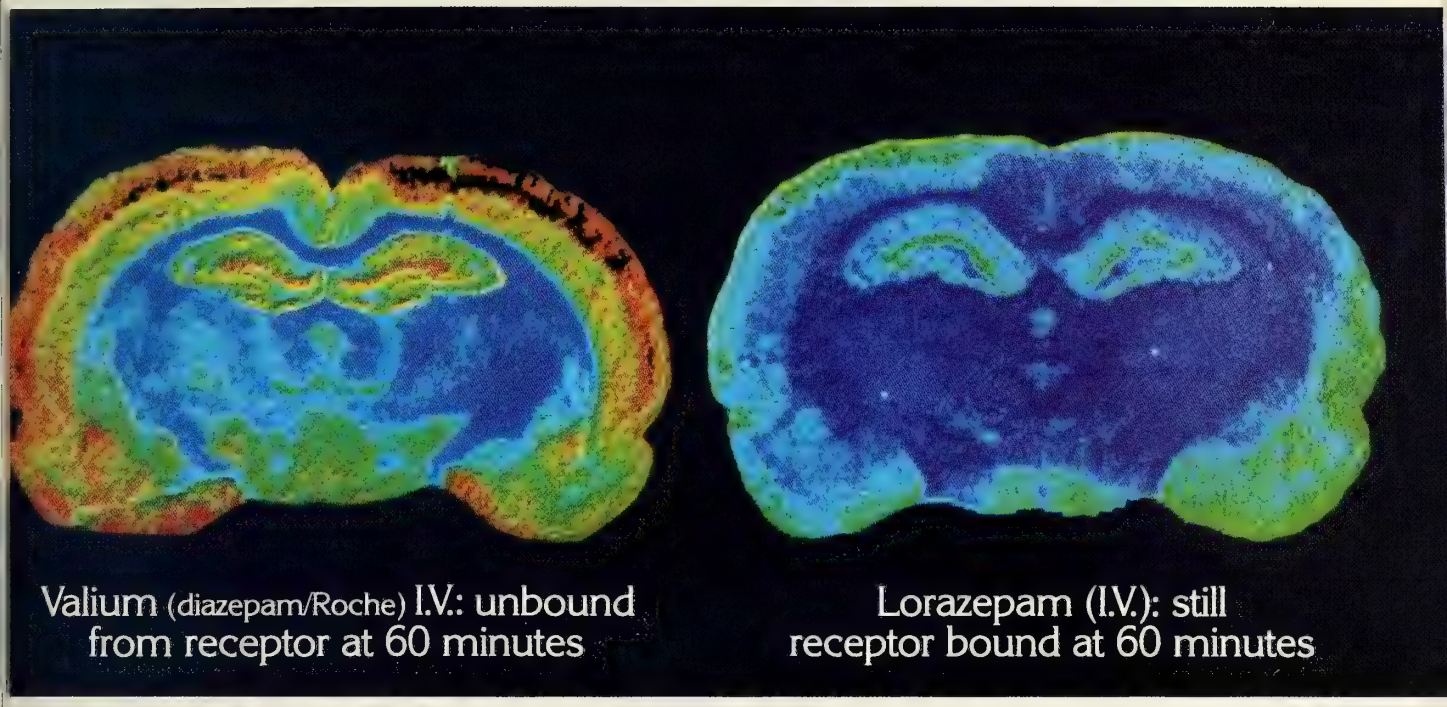
The officers and staff of ISMS and the Exchange have made themselves available to assist hospitals and county medical societies to organize action teams. In addition, all ISMS members have been sent a comprehensive document addressing the malpractice situation and samples of patient education material.

Through an order card included with the mailing, physicians were given the opportunity to order quantities of a brochure directed toward patients and an eye-catching display for waiting rooms or offices. Also included was a question and answer pamphlet which helps physicians answer questions from patients. The underlying message of the public education material is to encourage patients to write their own legislators in support of the ISMS/ISMIE proposals.

Patient-directed brochures will be distributed to ISMS members free of charge in any quantity desired. Copies may be obtained by returning the order card sent with the initial mailing, or contacting the Professional Liability Fulfillment Officer, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602, (312) 782-1654, #1148.

In discussing the professional liability issue, ISMS and ISMIE officers have stressed that the action team concept is the core of the initiative. The ISMS/ISMIE goal is to have an action team in place in every hospital or county medical society in the state. According to ISMS and the Exchange, it is only through intense involvement by physicians and others who support the medical profession that malpractice reform can be achieved. ◀

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The exact nature of the correlation between benzodiazepine binding sites and receptors in relation to clinical effect is still being defined. Considerable evidence supports the correlation. Although these animal results are consistent with clinical experience concerning relative duration of action, direct human data on receptor binding and human effects are still under investigation.

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Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome. *Oral forms* may be used adjunctively in convulsive disorders, but not as sole therapy. *Injectable form* may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion.

The effectiveness of diazepam in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets or capsules in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because their use is rarely a matter of urgency and because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins,* i.e., *dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Injectable Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least ⅓, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, *i.e.,* phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed and tolerated).

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug. Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and after diazepam therapy are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia. In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

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Dosage: Individualize for maximum beneficial effect.

ORAL: *Adults:* Anxiety disorders, relief of symptoms of anxiety—Valium tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 Valrelease capsules (15 to 30 mg) daily. Acute alcohol withdrawal—tablets, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 capsules (30 mg) the first 24 hours, then 1 capsule (15 mg) daily as needed. Adjunctively in skeletal muscle spasm—tablets, 2 to 10 mg t.i.d. or q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. Adjunctively in convulsive disorders—tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. *Geriatric or debilitated patients:* Tablets—2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (see Precautions). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose. *Children:* Tablets—1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use in children under 6 months). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose (not for use in children under 6 months).

INJECTABLE: Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.)

For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., *dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcohol withdrawal, 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children *administer I.V. slowly;* for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary; in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly, repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary, keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension. Dialysis is of limited value.

How Supplied:

ORAL: Valium round, scored tablets with a cut out "V" design—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100 and 500; Prescription Paks of 50, available in trays of 10. Tel-E-Dose® packages of 100, available in boxes of 4 reverse-numbered cards of 25, and in boxes containing 10 strips of 10.

Valrelease slow-release capsules—15 mg (yellow and blue), bottles of 100; Prescription Paks of 30.

INJECTABLE: Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

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ISMS Leadership Conference Focuses on Key Issues

Involvement and commitment were themes of the ISMS Leadership Conference, November 10-11 in Rockford. Some 250 members of ISMS and the ISMS Auxiliary attended the Conference. They heard rallying cries for the Society's Professional Liability Initiative and learned about Preferred Provider Organizations and other mechanisms of contracting for physician services.

In opening remarks, Dr. Robert C. Hamilton, ISMS president, stressed that professional liability and questions regarding alternative delivery systems were the "two major issues" confronting physicians today. He said the ISMS Leadership Conference had been organized with the express goal of "educating physicians about these issues and letting physicians know what they can do about them."

Professional Liability

The bulk of the conference's program centered on professional liability. In the opening session on Saturday, Dr. Fred Z. White, chairman of the Illinois State Medical Inter-Insurance Exchange's Board of Governors, offered an historical perspective on the malpractice problem and reviewed legislative proposals put forward by ISMS during the last session of the Illinois General Assembly.

"Basically, the ISMS proposals should accomplish three things," Dr. White told the audience. "They should provide for compensation to patients who are truly injured through negligence. They should curb the abuses of the legal system. And they should provide juries with better information to make realistic awards."

Proposals Outlined

Bills outlined by Dr. White designed to guarantee swift and fair compensation to injured parties were those which would provide for long term care with periodic payments and guarantee that patients would receive the majority of a damage award by establishing a sliding scale for attorney contingency fees.

Proposals to help juries reach reasonable conclusions were bills that would:

—Require juries to itemize awards;
—Reduce the jury award by other sources of compensation, such as health insurance;
—Place a limit on awards for non-economic losses;
—Require concrete proof for survivor claims in excess of $25,000 in wrongful death actions.
—Eliminate damages assessed to punish physicians; and
—Establish standards for expert witnesses.

Attempts to curb abuses of the legal system would be made through bills which would (1) make it easier for physicians to recover legal costs stemming from frivolous suits; (2) establish screening panels to determine validity of suits; (3) permit dismissal of physicians not actually involved in an incident; (4) establish liability for patients and attorneys who make false allegations; and (5) reduce the burden of evidence necessary to prove a suit was filed with malicious intent.

Constitutional Issues Addressed

In describing the ISMS legislative proposals, Dr. White said that many were similar to bills which have been proposed before in Illinois and other states. Dr. White explained that while bills similar to some of the Illinois measures had been ruled unconstitutional by the state's Supreme Court in the past, the structure of this legislation had been changed to meet constitutional objections. Also, the earlier legislation had plowed new legal ground, and since then, several years' case law had further defined what the Supreme Court might find acceptable.

Legislators' Perspectives

Following Dr. White's presentation was a panel discussion featuring Sen. Terry Bruce (D-Olney); Sen. Aldo DeAngelis (R-Chicago Heights); Rep. Sam Vinson (R-Clinton); and Rep. Aaron Jaffe (D-Skokie). Senators Bruce and DeAngelis and Representative Vinson were sponsors of ISMS' 1984 legis-

lation. Representative Jaffe was chairman of the House Judiciary Committee which had refused to approve the bills for consideration by the full House.

Senator Bruce characterized the ISMS bills as "trying to adjust the balance" in the handling of medical malpractice cases. He maintained that public support would be necessary to pass malpractice reforms. He suggested that physicians educate their patients about the extent of the problem by itemizing on patient bills the portion of charges that represents the patient's burden in providing for the physician's malpractice insurance costs.

In explaining his support for the ISMS legislation, Sen. DeAngelis cited rapidly escalating health care costs. The Senator said that the malpractice problem should be viewed from a broader perspective. He emphasized that high health care costs of employee benefit programs—due in part to professional liability—are forcing major employers to look toward other states when locating their manufacturing plants.

Representative Vinson was pessimistic about the chances that the lawyer-dominated House Judiciary Committee would approve sweeping malpractice reforms. However, he said overwhelming outside pressure on legislators in the form of public opinion and grassroots lobbying by physicians could overcome the committee roadblock. Representative Vinson also encouraged physicians to enlist the support of their personal attorneys to help convince legislators that malpractice reform was not a "doctor vs. lawyer" issue.

Defending the House Judiciary Committee's refusal to approve the ISMS legislation, Rep. Jaffee criticized the bills, saying they were "too ambitious" and were "taking away people's rights." Representative Jaffe conceded that physicians had a problem with too many frivolous lawsuits, but urged physicians to "sit down and start talking with attorneys" rather than engaging in a "legislative shootout."

Representative Jaffe urged physicians—when pursuing legislative reforms—to consider what he called "Jaffe's law of Legislative Problem Solving": (1) A problem is not a problem unless it's a crisis; (2) A crisis is not a crisis unless a politician's job is at stake; (3) A solution is not a solution unless the media says it is; and (4) A crisis is not over until the public loses interest.

Following the general sessions, two malpractice-oriented workshops were held. These addressed methods to organize local physicians for the professional liability initiative and to instruct physicians in effectively presenting arguments in public meetings and media appearances.

Action Teams

The workshop on organization was led by Dr. Alfred J. Clementi, chairman of the ISMS Board of Trustees, who encouraged physicians to form "action teams" in their hospitals or county medical societies. Such teams would be charged with coordinating communication between the hospital or society and legislators, local media, community groups and attorneys. Key individuals suggested by Dr. Clementi for inclusion on action teams were ISMIE Network Representatives, ISMS Key Contacts and other physician leaders, hospital administrators, hospital board members, auxiliary representatives, nurses and other interested hospital employees.

Dr. Clementi's workshop also featured a brief slide show developed by ISMS for physicians to present at civic club meetings and other public gatherings. (Copies of the slide show may be borrowed from ISMS headquarters.)

Effective Communication

The second malpractice workshop concentrated on improving physicians' abilities to communicate effectively with the public and media regarding malpractice reform. The workshop was conducted by representatives of Burson-Marsteller, the public relations agency retained by ISMS to assist with the professional liability initiative.

"Talk in terms the public will understand" was the first communications rule presented by the Burson-Marsteller executives. They also emphasized that, before speaking about malpractice, physicians should "think about what the audience needs to know, what will persuade them and what they will accept."

Because the complexity of the malpractice issue can interfere with good communication, physicians were urged to stick to several "key messages" when discussing professional liability:

1. Everyone pays the cost of today's malpractice crisis, often without realizing it.
2. Malpractice-related costs are the fastest growing element in the overall increase in health care costs.
3. These costs stem from the practice of defensive medicine, malpractice insurance premiums, taxpayer dollars to support the court system where the suits are processed and tried, and multi-million-dollar awards granted by juries.
4. The problem is the abuse of the judicial system as seen in the filing of hundreds of frivolous malpractice lawsuits.
5. Besides costing millions of dollars, these frivolous cases are cluttering the courts and delaying for years the trials of truly injured patients.
6. The malpractice problem has reached such crisis proportions in Illinois that an urgent solution is needed.
7. ISMS will propose a legislative package to improve the system for handling malpractice claims.
8. The proposals are designed to: (1) Protect the rights of patients truly injured by physician negligence; (2) Curb the abuses of the judicial system by reducing the hundreds of frivolous suits; and (3) Help juries do a better job with the difficult task of determining fair compensation by providing more information.
9. Malpractice is an area where all of us working together can stem the tremendous increases in health care costs, so call/write your legislators and the local media.

When answering questions about malpractice, a physician should try

to gauge the questioner's intent and restate the question in the physician's own language, according to Burson-Marsteller. Restating the question allows one to "buy time" to think, neutralize any harsh language, and broaden the question to include the key messages in the answer.

Media Relations

During the Sunday morning plenary session, Burson-Marsteller representatives returned to coach physicians in dealing with local news media. Physicians were presented with possible story angles to discuss with local reporters, and warned of possible pitfalls in dealing with the media. Dr. Morgan M. Meyer, ISMS president-elect, moderated the Burson-Marsteller presentation.

The importance of enlisting media aid was reiterated by Rep. Judy Baar Topinka (R-Berwyn) who encouraged physicians to "take your local newspaper reporter or publisher to lunch" to discuss the malpractice situation. Representative Topinka stressed that the support of the news media would be an important factor in overcoming resistance to malpractice reform by the lawyer-dominated judiciary committees in the House and Senate.

Work Needed Now

Representative Topinka strongly encouraged physicians to return to their hospitals and county medical societies to organize action teams to coordinate communication with legislators. Although the legislation would not be considered until the legislature begins work in earnest in March, Rep. Topinka emphasized that work must begin now if the ISMS effort is to be successful.

Following Rep. Topinka's rallying speech, the audience was broken into small groups based upon legislative districts. ISMS staff members were assigned to each group to discuss the mechanics of organizing the initiative at the local hospital or county medical society level.

ISMIE Network Active

In another session related to malpractice, the Illinois State Medical Inter-Insurance Exchange sponsored a breakfast to discuss the malpractice situation as it directly pertains to the Exchange and the Exchange's Network Representatives. ISMIE Network Representatives are physicians who have agreed to serve in their hospitals as a resource for information concerning ISMIE and professional liability in general.

Featured speakers at the breakfast were the members of the ISMIE Policyholder Services Committee: Drs. Boyd E. McCracken, chairman, Julian Buser, Henri Havdala, David Littman and Morris T. Friedell. Topics addressed included the financial position of the Exchange, an update on Guaranty Fund Certificate redemption, the role of the Network regarding hospital requirements for professional liability insurance, and the role of the Network in the ISMS Professional Liability Initiative.

Alternative Delivery Systems

The Saturday luncheon session featured an overview of the trend toward alternative delivery systems as a cost saving mechanism. Featured speaker was Jack Wood, J.D., chairman of the health care law firm of Wood, Lucksinger and Epstein.

Wood emphasized that there was a need for physician-hospital cooperation to meet the challenges posed by increasing numbers of Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs) and Independent Practice Associations (IPAs). While potential areas of physician-hospital conflict existed, Wood maintained that physicians and hospitals were natural allies and should be able to work together.

ISMS Help Available

Also announced at the program was formation of a special ISMS Office of Contractual Services. Through this newly-established activity, physicians who are considering signing a PPO, HMO or IPA contract can submit the contract to the Society for a standardized review of its provisions by legal counsel.

Additional information on the Office of Contractual Services was to be sent to the ISMS membership in the near future.

PPO Session

In a Saturday afternoon workshop, Wood returned to conduct an in depth discussion of PPOs, including a look at how they operate, examples of economic incentives provided, and legal issues surrounding their development.

According to Wood, typical operational features of PPOs are that:

—Patients are steered to panel providers through economic incentives;

—Patients are permitted to trade less freedom of choice for lower out-of-pocket costs; and

—Physicians and hospitals agree to negotiate prices and utilization or effectiveness controls in return for expectation or promise of greater patient volume.

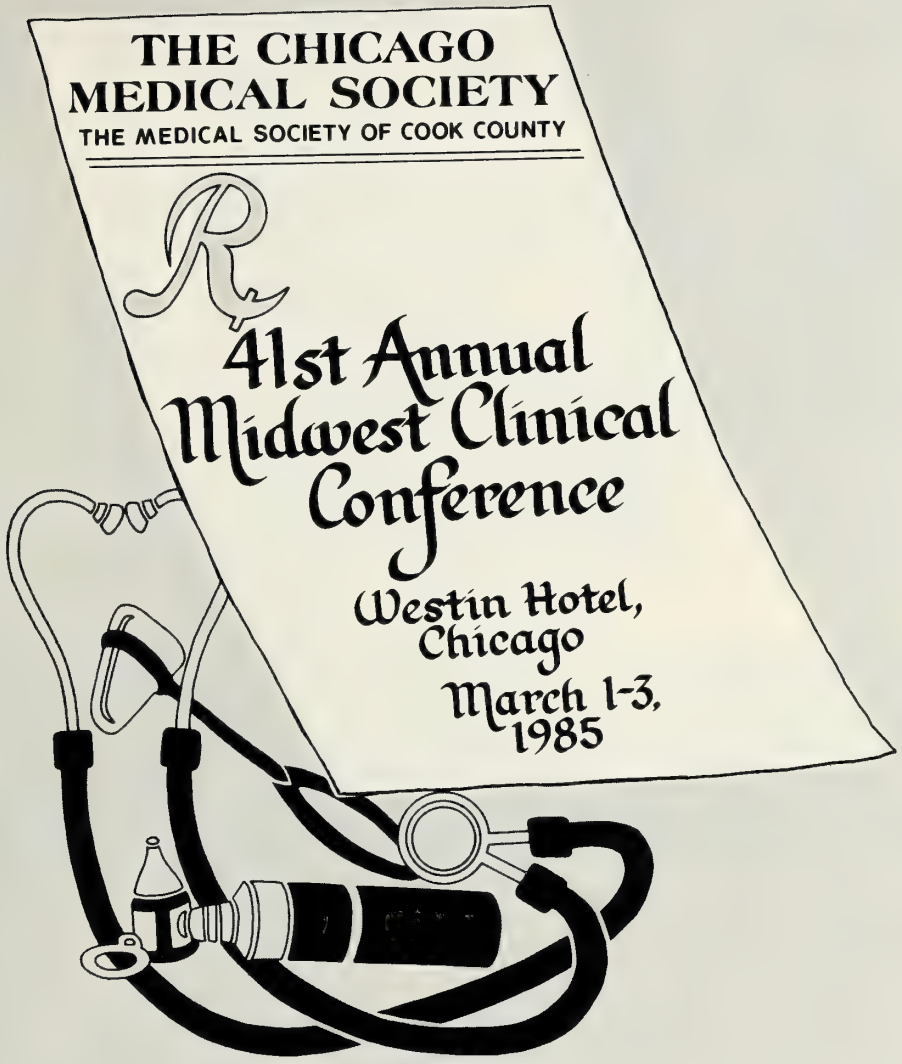
Legal questions raised by PPOs were cited by Wood. These included patient solicitation and fee splitting prohibitions; risks of price-fixing complaints related to setting fee schedules and potential allegations of monopoly by excluded providers.

Also important, according to Wood, were professional liability risks associated with PPO practice. Issues arising in this area were whether strict effectiveness review compliance will expose physicians to additional liability risks and whether the PPO itself be named as a defendant in malpractice claims against panel physicians and hospitals.

Wood concluded with a look at the structure, organizational alternatives and administration of PPOs, and the mechanics of contractual agreements, practice pattern review and physician reimbursement under PPOs.

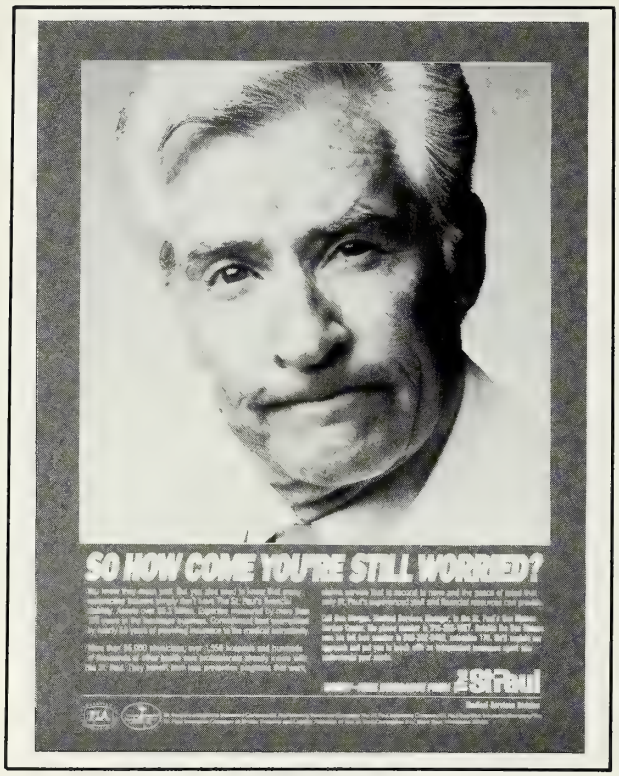
The Leadership Conference program also featured a Saturday dinner address by Douglas Kiker, the NBC television network's national affairs correspondent. Kiker, who has covered every national political convention since 1964, offered his audience a look behind the scenes of television news coverage and the Washington political scene. ◀

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The AAMA is a professional association, formed 31 years ago. It is a tri-level organization for individuals who work under the supervision of physicians, in the physician's office, hospitals or other facilities, performing administrative and/or clinical duties. Its national, state and local chapters are doorways to professionally directed programs, designed to improve the abilities of your assistants in the delivery of health care. The AAMA is a nonprofit organization. It is not, nor shall it ever become, a trade union or collective bargaining agency. The AAMA is generously endorsed by the AMA and the ISMS and we fully endorse the programs and functions of the AAMA.

A medical assistant is defined as anyone who works under the supervision of a physician licensed to practice medicine, and AAMA membership is open to receptionists, secretaries, bookkeepers, nurses, technicians or any person assisting within your range of supervision.

Continuing education is the main objective of AAMA. There is ready access to state and nationally sponsored programs, including self-study courses and advisory help. Education classes are held regularly, and lectures are conducted by physicians and other professionals supporting the practice of medicine.

Group life, medical, long-term disability and professional liability insurance is available to members at reduced premiums. AAMA also encourages advancement of medical assistants by offering a Certification Examination designed to recognize professional competency.

There is a local chapter of AAMA near you that meets monthly, usually in the evening. At these meetings medical assistants learn new capabilities and enjoy the fellowship of their co-workers in the community.

Dues currently are $66.00 for state and national. Chapter dues vary from $5.00 to $10.00. Dues are payable yearly on January 1. The dues include membership on the county (chapter), state and national levels and state and national educational periodicals.

In supporting the AAMA, by enrolling your medical assistant in the local chapter, you will be supporting your own practice of medicine in a highly professional manner.

American Association of Medical Assistants, Illinois Society, Physician Advisors

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Further information about the Illinois Society, AAMA, may be obtained by contacting one of the officers: Anna Cannon, president, 7443 S. Luella, Chicago IL 60649; Betty J. Kronemeyer, CMA, immediate past president, 809 N. 10th, Mascoutah IL 62258; Ehlma Garcia, CMA-EMT, president-elect, 6134 S. Tripp, Chicago IL 60629; Cheryl Hutchison, CMA, first vice president, 53 Lockhaven, Granite City IL 62040; or Betty Jean Meier, second vice president, 2812 Barber Green Road, DeKalb IL 60115.

Report on Interim Meeting

AMA Hospital Medical Staff Section

Illinois had the largest delegation attending the interim meeting of the AMA Hospital Medical Staff Section in Hawaii, November 29-December 3, 1984. A total of 53 Illinois hospital medical staff representatives were present to voice their concerns and viewpoints on issues pertinent to medical staffs. There were 460 representatives of medical staffs from 45 states that attended the meeting. There was discussion on 54 resolutions and seven major reports.

The influence of the Section on AMA policy can be seen from the fact that of 14 resolutions referred by the Section to the AMA, 10 were adopted by the AMA House of Delegates, two were referred to the AMA Board of Trustees and only two were not adopted. Among other issues, self-governance of the medical staff continued to be a priority concern of the Section.

Illinois submitted three resolutions at the meeting. One urged a study on "joint ventures" so that medical staffs would properly evaluate the advantages and disadvantages of such business venturing with the hospital. This concept was embodied in a resolution which passed the Section and was subsequently adopted by the AMA House of Delegates. A second Illinois resolution, dealing with the timing of governing council elections, was referred to the Section governing council. The third Illinois resolution regarded hospital rules which may be obstacles to a physician's response in an emergency situation. This was adopted by the Section, but not adopted by the AMA House of Delegates. The rationale for the AMA action on this resolution was a perception that current JCAH standards can be interpreted to prohibit such hospital rules.

The Section adopted a report from the governing council on an Illinois resolution introduced and referred at the June 1984 annual meeting. The resolution urged a seat on the AMA Board of Trustees for a Section representative. The report recommended against such a seat at this time, but urged continued evaluation of the suggestion.

More detailed information on the meeting will soon be provided by the AMA to all medical staffs.

Clearly, interest in the Section is very high across the nation, and Illinois is no exception. In order to maintain and even expand Illinois strength in the Section, all medical staffs are strongly urged to select a representative to the Section. The only prerequisites are that the representative be an AMA member, (and a member of ISMS and the county society) have clinical privileges at the hospital, and that he/she be elected by the active voting membership of the medical staff.

The next meeting of the AMA-HMSS will be June 13-16, 1985 in Chicago. For further information on the Section, contact the Division of Membership Services at ISMS (312-782-1654). ◀

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*Additional diagnostic information on page 52

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Adverse Reactions: *Cardiovascular:* Hypotension, tachycardia, syncope. *Respiratory:* Rarely, respiratory depression. *CNS. Acute CNS Manifestations:* In rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours; may recur if drug is reinstituted. *Other CNS Effects:* Dizziness, lightheadedness, sedation, euphoria, disturbed dreams, hallucinations, irritability, excitement, tinnitus, tremor. *Gastrointestinal:* Nausea, vomiting, constipation, diarrhea, anorexia, rarely abdominal distress. *Allergic:* Edema of the face; dermatitis, including pruritus; flushed skin, including plethora. *Ophthalmic:* Visual blurring and focusing difficulty. *Hematologic:* Depression of white blood cells (especially granulocytes), which is usually reversible, moderate transient eosinophilia. *Other:* Headache, chills, insomnia, weakness, urinary retention.

Drug Abuse and Dependence: *Controlled Substance.* TALWIN Nx is a Schedule IV controlled substance.

Dependence and withdrawal symptoms have been reported with orally administered pentazocine. Patients with a history of drug dependence should be under close supervision. Possible abstinence syndromes in newborns after prolonged use of pentazocine during pregnancy have been reported. In prescribing for chronic use, the physician should take precautions to avoid increases in dose by the patient. Tolerance to the analgesic effect is rarely reported; there is no long-term experience with oral use of TALWIN Nx.

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EKG

(Continued from page 13)

Answers: 1. C 2. A, B, C

This patient illustrated the complex problems that can occur when a severe anemia complicates heart disease. Her initial arrhythmia was atrial fibrillation but postoperatively she developed premature ventricular beats and non-sustained ventricular tachycardia. Quinidine was used to treat this. This arrhythmia then appeared. It is atrial flutter with a variable atrioventricular (AV) block marked in Lead III. Quinidine depressed the conduction in this enlarged atrium and allowed the emergence of atrial flutter but at a relatively slow flutter rate of about 220 beats per minute. The variability in AV conduction is caused by digitalis effect but not intoxication. There is no ventricular hypertrophy or advanced AV block present here. Cardiac catheterization demonstrated severe mitral stenosis with a 12mmHg valve gradient and a pulmonary artery pressure of 60/24mmHg. The left ventricular and coronary angiograms were normal. A mitral commissurotomy was successfully performed.

The anemia had to be explained before the cardiac catheterization study or mitral valve surgery could be performed. The anemia had developed slowly but still contributed to her complaints of dyspnea and easy fatigue. In the setting of chronic anemia, the onset of heart failure usually means underlying heart disease, such as occurred here. When the hemoglobin falls below seven grams/dl, cardiac output increases. The underlying valvular or coronary heart disease can be aggravated by the requirement of increased cardiac output created by the anemia.

The differential diagnosis of the anemia in this patient included: (1) subacute bacterial endocarditis, (2) microangiopathic hemolytic anemia, (3) drug-induced anemia and (4) hemoglobinopathy. Lack of fever or positive blood cultures and peripheral blood smear analysis made the first two considerations unlikely. Although many antiarrhythmic, antihypertensive, and diuretic medications can cause blood dyscrasias, this did not apply here. No abnormal or fetal hemoglobin was present. A bone marrow aspiration and later biopsy showed decreased erythropoiesis and megakaryocytic hyperplasia. Chromosome studies showed the deletion of the long arm of chromosome #5. The refractory anemia was the result of a myelodysplastic syndrome manifested by this karyotypic abnormality. This is called the 5q-syndrome. The 5q-karyotype may be associated with a distinct hematologic picture consisting of a macrocytic anemia without ringed sideroblasts, low to normal leucocyte counts, and elevated platelet counts with large numbers of megathrombocytes.

In follow-up of these platelets with 5q-syndrome, none has undergone leukemic transformation. For more information on this entity, see T. Mahmood, *et al.: Amer J. Med.* 66:946, 1979. ◀

The Illinois Department of Rehabilitation Services Bureau of Disability Adjudication Services announces a substantial increase in its

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For more information, please contact:

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Chief Medical Consultant
Bureau of Disability Adjudication Services
Illinois Department
of Rehabilitation Services
P.O. Box 3842
Springfield, Illinois 62708
Telephone 217/782-4902

Obituaries

****Bulfer, Andrew F.,** Chicago, died November 14 at the age of 81. Dr. Bulfer was a 1931 graduate of the Loyola University Stritch School of Medicine, Maywood.

***DeYoung, Henry D.,** South Holland, died November 14 at the age of 62. Dr. DeYoung was a 1946 graduate of the University of Illinois College of Medicine, Chicago.

****Forbrich, Joseph A.,** River Forest, died October 20 at the age of 78. Dr. Forbrich was a 1932 graduate of Loyola University Stritch School of Medicine, Maywood.

***Forrette, Clarence J.,** Washington, died November 7 at the age of 66. Dr. Forrette was a 1943 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Goldstein, Isak,** Lincolnwood, died October 26 at the age of 63. Dr. Goldstein was a 1953 graduate of Medizinsche Fakultat de Universitat Graz, Austria.

***Gottschalk, William,** Winnetka, died October 22 at the age of 58. Dr. Gottschalk was a 1953 graduate of Faculte de Medecine et de Pharmacie Universite Libra de Bruxelles, Belgium.

***Herzon, Emanuel M.,** Elgin, died November 23 at the age of 66. Dr. Herzon was a 1942 graduate of the University of Illinois College of Medicine, Chicago.

****Leshin, Norman,** Chicago, died November 10 at the age of 83. Dr. Leshin was a 1926 graduate of Rush Medical College, Chicago.

***Lipov, Mary J.,** Chicago, died November 8 at the age of 53. Dr. Lipov was a 1954 graduate of Kiev Medical Institute, Kiev.

****Lorance, Luther M.,** Chicago, died November 14 at the age of 87. Dr. Lorance was a 1926 graduate of the University of Illinois College of Medicine, Chicago.

***Pacold, Otakar G.,** Berwyn, died October 8 at the age of 69. Dr. Pacold was a 1939 graduate of Lekarska Fakulta Universita, J.E. Purkyne, Brno, Czechosolvakia.

***Pugh, Charles E., Jr.,** Oak Park, died November 17 at the age of 74. Dr. Pugh was a 1937 graduate of Northwestern University Medical School.

***Ranke, Eugene J.,** Wilmette, died November 27 at the age of 69. Dr. Ranke was a 1942 graduate of the University of Illinois College of Medicine, Chicago.

***Schmidt, John L.,** Highland Park, died November 3 at the age of 69. Dr. Schmidt was a 1950 graduate of Case Western Reserve University School of Medicine, Cleveland.

***Singh, Nerissa P.,** Chicago, died April 23 at the age of 78. Dr. Singh was a 1950 graduate of the University of Health Sciences/Chicago Medical School.

***Trobaugh, Frank E., Jr.,** Chicago, died November 10 at the age of 64. Dr. Trobaugh was a 1943 graduate of Harvard Medical School, Boston.

***William, R. Davis,** Hopedale, died November 12 at the age of 46. Dr. William was a 1964 graduate of Stanley Medical College Madras University, Madras, India.

****Young, Warren W.,** Evansville, Indiana, died November 24 at the age of 74. A past president of the Chicago Medical Society and a former ISMS trustee, Dr. Young, was a 1935 graduate of the University of Illinois College of Medicine, Chicago.

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Additional NMR Information on page 46

IMJ

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Illinois State Medical Society

Volume 167, No. 1
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Use of DSA for Diagnosis of Takayasu's Arteritis

By Lee Sider, M.D., Richard A. Mintzer, M.D., Rolf F. Vrla, M.D. and Ellen B. Mendelson, M.D./Chicago

Angiography has long been considered the diagnostic test of choice to confirm a diagnosis of Takayasu's arteritis. Other studies may suggest the diagnosis, but actual visualization of the aorta and large arterial stenoses is required. We have found that Digital Subtraction Angiography (DSA) with its reduced morbidity, reduced examination cost and ease of performance offers excellent visualization of the diseased artery or arteries. This paper presents two cases of Takayasu's arteritis where a diagnosis was made quickly and definitively with the use of DSA via an intravenous route.

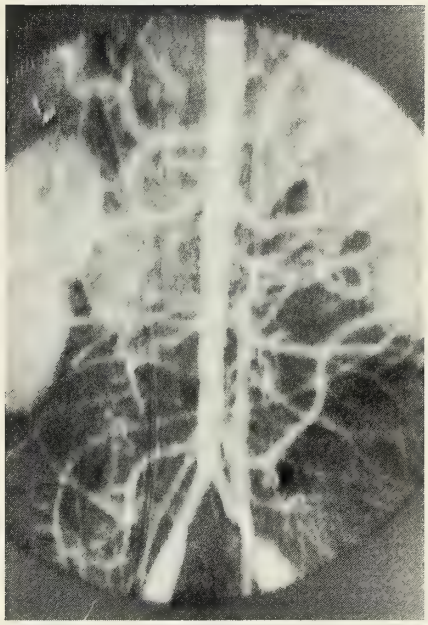


Figure 1: DSA of the aorta and proximal iliac arteries identified bilateral common iliac artery narrowing.

A 29 year old Hispanic female first presented to an outlying hospital with severe headaches, epistaxis and nausea. She had a two year history of hypertension, cough and dyspnea on exertion (three blocks). Her blood pressure was 224/90 on apresoline. On examination, she was lethargic with a mild right hemiparesis. Blood urea nitrogen, serum creatinine, and serum potassium were elevated. A chest Xray was reported to be normal. Renal biopsy revealed changes of rapidly progressive glomerulonephritis. The patient was placed on hemodialysis and corticosteroids.

Six weeks later the patient came to our hospital for the first time seeking revision of her dialysis fistula. She was without complaints. Blood pressure remained elevated. Physical examination revealed normal peripheral pulses, but bruits were heard over the abdomen and extremities. Digital subtraction angiography showed narrowing of the distal abdominal aorta and both proximal iliac arteries consistent with an arteritis (Figure 1).

Biopsy of the renal artery at the time of subsequent renal bypass surgery, (initiated to address uncontrollable hypertension) established the diagnosis of Takayasu's arteritis. A later conventional angiogram had demonstrated a new renal artery stenosis.

During the most recent admission she complained of sudden onset left sided chest pain radiating to the infrascapular region. Chest radiograph now revealed oligemia of the right lung and slight elevation of the right hemidiaphragm (Figure 2). A ventilation-perfusion lung scan showed absence of perfusion to the right lung with normal ventilation (Figure 3). On digital subtraction angiography, the right pulmonary artery had a narrowed, "rat-tail" appearance (Figure 4). A pulmonary arteriogram confirmed the abnormality (Figure 5). A diagnosis of Takayasu's arteritis involving the right pulmonary artery was made. The patient's pain resolved spontaneously without therapy.



Figure 2: PA view of the chest demonstrates asymmetry of the pulmonary vasculature with no right main pulmonary artery identified.

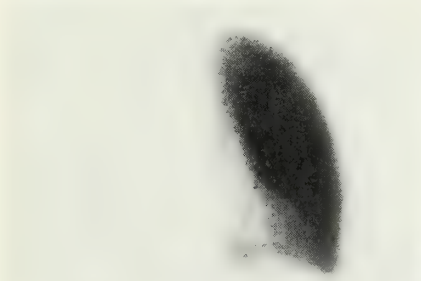


Figure 3: Technetium macro aggregated albumin perfusion lung scan demonstrates almost total lack of perfusion to the right lung. The ventilation scan was normal.



Figure 4: DSA of the pulmonary artery confirms the absent right pulmonary artery and shows only a linear band of contrast approaching the right hemithorax.

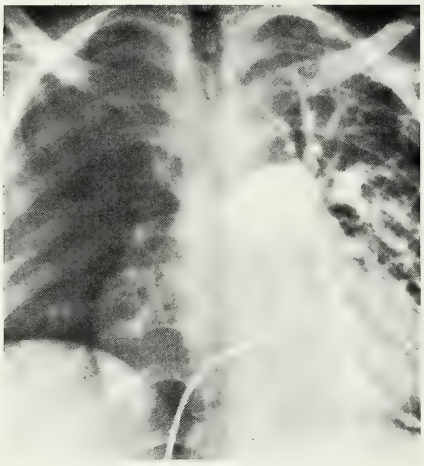


Figure 5: Pulmonary angiography agains confirms the absent right pulmonary artery and shows only "rat-tail" remnant of the artery.

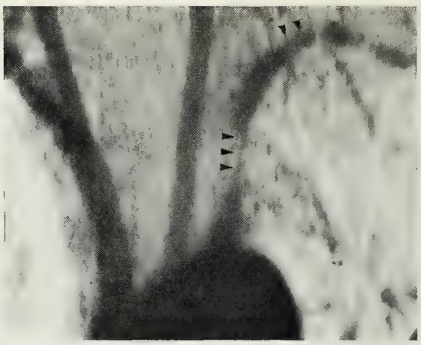


Figure 6: Digital angiographic views demonstrate the two areas of stenosis in the proximal and distal left subclavian artery.

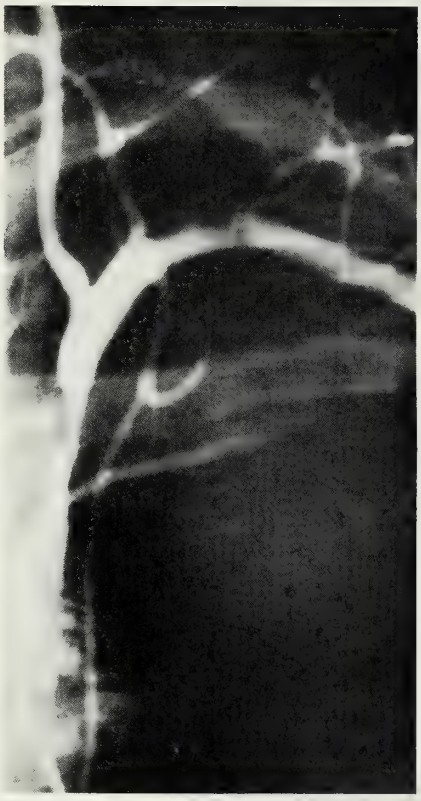


Figure 7: The corresponding conventional angiogram.

Second Case

The second patient was a 34 year old female who complained of progressive weakness marked most recently by tingling in the left upper extremity. Physical examination revealed deficient left arm pulses. A digital subtraction angiogram identified an area of irregular narrowing of the proximal ascending left subclavian artery (Figure 6, large arrows) as well as some irregularity of the more distal portion of this artery (Figure 6, small arrows). A conventional angiogram confirmed these findings (Figure 7). On the basis of clinical presentation and radiographic findings a diagnosis of Takayasu's arteritis was made. An angioplasty of the proximal lesion was successfully performed. Repeat DSA (Figure 8) two weeks after surgery for baseline confirmed the success of the angioplasty; a conventional angiogram confirmed the DSA findings (Figure 9). The patient remains symptom free six months after angioplasty.

Discussion

Takayasu's arteritis is a rare disease with less than 300 cases reported in the world literature as of 1972. It most often affects females (90%) under 30 years of age.[1] Takayasu's has a world wide distribution. Pathologically, it is a giant cell arteritis involving, most commonly, the subclavian artery, descending aorta, renal artery and carotid artery.[2] Involvement of the main pulmonary artery and larger arterial branches approaches 50%



Figure 8: Post-angioplasty study.

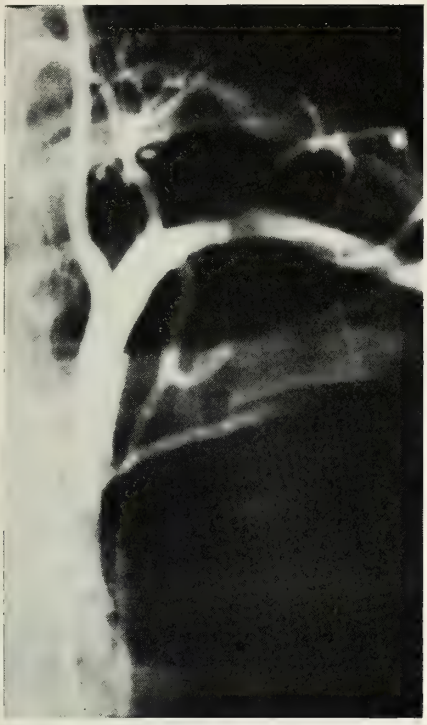


Figure 9: Followup, baseline conventional post-angioplasty arteriogram corresponding to Fig. 8.

of cases.[3]

Chest Xray may show widening of the aortic shadow, irregularity of the descending aorta, aortic calcification, cardiomegaly and rib notching (especially the 9-12th). In the presence of pulmonary artery disease there is sparseness of the pulmonary vasculature to the sites involved.[4]

The angiogram, both digitally subtracted images and conventional studies, demonstrates abrupt transition from diseased to normal arteries. Classically, the involved segments are either stenotic or dilated, and they appear smooth unless there is superimposed atherosclerosis. Stenotic aortic lesions are seen mainly about the diaphragm or distal to the left subclavian artery. They do not occur in the ascending aorta. The aortic involvement is usually diffuse with concomitant branch stenoses. Aneurysm formation is also common.[4]

The distal and proximal subclavian arteries are the most frequently involved of the branch vessels. The occluded carotids may show a peculiar "flame-shaped" stump. The renal arteries are also commonly involved with the abdominal extension of Takayasu's arteritis.[4]

Treatment includes hypertension management, corticosteroids, surgery (reocclusions are common), and more recently, angioplasty.[5] There has been one reported case of a recanalized renal artery without any treatment.

DSA can be performed via an intra-arterial or intravenous route. Intra-arterial digital examinations offer the ability to make a diagnosis with the use of reduced contrast loads, which is often of benefit in these patients with frequent renal compromise. This is not the case with intravenous injections. The intravenous studies allow rapid diagnosis in debilitated patients who could not tolerate a conventional study. The intravenous studies are also associated with fewer complications. The exam is considerably less expensive because it does not necessitate hospitalization and performance requires less physician training.[6]

The two presented cases illustrate aortic, iliac and pulmonary arteritis demonstrated on digital examination that was confirmed by conventional angiography. As experience with DSA grows, it should become the radiographic study of choice for diagnosis in Takayasu's arteritis as well as other vascular processes that could only be studied with arteriography in the past.

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Ellen B. Mendelson, M.D., is a board certified radiologist affiliated with Northwestern Memorial Hospital in Chicago. Dr. Mendelson is presently a fellow in angiography at Northwestern.

Rolf F. Vrla, M.D., is a board certified radiologist currently in private practice in Phoenix, Arizona. Dr. Vrla completed his residency and a fellowship in angiography at Northwestern Memorial Hospital in Chicago.

Richard A. Mintzer, M.D., is a board certified radiologist currently on staff at Northwestern Memorial Hospital in Chicago. Dr. Mintzer is a professor of radiology at Northwestern University Medical School. He is soon to assume the chairmanship of the department of radiology at Highland Park Hospital in Highland Park, Illinois.

Lee Sider, M.D., is a board certified radiologist who serves as acting chief of chest and digital imaging at Northwestern Memorial Hospital in Chicago. Dr. Sider is an assistant professor of radiology at Northwestern University Medical School.

Present Day Role of the Chest X-Ray

Initial Evaluation of Pulmonary Tuberculosis

By Seymour S. Langer, M.D./Chicago

The admitting chest x-ray accurately differentiated between clinically active and inactive tuberculosis in 200 consecutive cases of tuberculosis.

The charts of 200 consecutive patients discharged prior to 1982 from a city hospital with a diagnosis of tuberculosis were reviewed in an attempt to define the present-day role of the chest x-ray in the diagnosis of tuberculosis.

The chest x-ray was born and grew out of the need to diagnose and follow tuberculosis. In the late forties and fifties millions of mass survey x-ray films were taken every year, financed largely by private Christmas Seal funds. The parallel discovery and use of effective antituberculosis medication has resulted in the present day situation: the incidence of tuberculosis has "bottomed out" and the organism has apparently decreased in virulence.

In the United States today, the problem of tuberculosis is largely one of persistent disease among indigent persons and recent arrivals from third world countries. Who knows what the day after tomorrow will bring? It is worthwhile to remember that many in the medical profession once believed that the advent of penicillin rendered gonorrhea and syphilis obsolete.

Table 1
X-Ray Findings in 164 Patients Indicative of No Active T.B. As Supported by the Subsequent Finding of a Negative Sputum

Right upper lobe fibrosis	15
Left upper lobe fibrosis	23
Calcifications	15
Old granulomas	19
Thickened pleura	10
Old surgery for T.B.	6
Bullae	4
Bullae and fibrosis	10
Cystic changes	6
Old scarring	12
COPD	5
Blunted CP angles	5
Fibronodular changes	17
Calcified granulomas	11
Normal chest	6

Today, the chest x-ray plays a role in evaluating the activity of tuberculosis rather than in its initial detection. In 164 of the 200 cases reviewed, the clinical diagnosis was made on a history of previous disease with or without previous treatment. Given the assumed diagnosis of tuberculosis, the initial chest film correlates remarkably well with the initial or eventual demonstration of the presence or absence of acid fast organisms.

In all 164 patients where the chest film showed findings of old scarring in its various forms, the sputum was always negative for acid fast organisms. When a chest film was reported as showing no evidence of active pulmonary disease the clinician could be fairly certain that tuberculosis was not part of the clinical picture. The converse was also true. In the 36 patients whose chest films indicated active pulmonary disease, the sputum was always positive. In one case of presumed active pulmonary disease, the sputum smear was negative for acid fast bacillus, but the cultures were posi-

Table 2
X-Ray Findings in 36 Patients Indicative of Active T.B. as Supported by the Subsequent Finding of a Positive Sputum

Pleural effusion	5
Infiltrates	5
Apical infiltrates	11
Cavitation	3
Cavitation and infiltrates	12

Table 3
Sex Distribution of Patients With Diagnosis of T.B.

Female	56
Male	144

Table 4
Year of Birth of Patients With Diagnosis of T.B.

1890-1900	3
1900-1910	10
1910-1920	25
1920-1930	33
1930-1940	50
1940-1950	39
1950-1960	19
1960-1970	15
1970-1980	4
1980-1981	2

tive. In the presence of x-ray evidence of active pulmonary disease on a chest film, the history of previous treatment seemed to make no difference as to whether or not the disease was clinically active. Findings of apparently active pulmonary disease on a chest film should be taken as *prima facie* evidence of clinical activity until proven otherwise.

The presence of thoracoplasty on a chest film poses a slightly different problem. Thoracoplasties were done as a last resort for persistent cavitary disease. The procedure was never designed with "cure" in mind. The idea was to "treat" by putting an area of disease "at rest" by releasing tension on cavities. The number of chest films we still see with thoracoplasties in people with no active pulmonary disease is good testimony to the effectiveness of the procedure. Remember, the patient whose film shows a thoracoplasty once had cavitary disease and without the thoracoplasty would have been dead. The clinical evaluation of a patient with respiratory symptoms and an old thoracoplasty is a bit different. Does he or does he not have active disease on x-ray? Sometimes tomography will demonstrate the presence or absence of cavities in a thoracoplasty bed.

Tables 1 and 2 list the x-ray findings indicative of non-clinically active tuberculosis and active tuberculosis.

Summary

Of 200 consecutive patients discharged from a large city hospital through December 1981, 36 patients had x-ray findings of active pulmonary disease. All 36 had positive sputum for acid fast disease. A total of 164 patients had x-ray findings indicative of no active disease. All 164 had negative sputum for acid fast disease.

Seymour S. Langer, M.D., is a board certified radiologist affiliated with the University of Illinois hospitals in Chicago. Dr. Langer is an associate professor of radiology at the UI Abraham Lincoln School of Medicine and chief of radiology for the City of Chicago Clinics and Hospital. He is the former chief of radiology for the City of Chicago Municipal Tuberculosis Sanitarium and Clinics. Dr. Langer also serves as a consultant for both the Suburban Cook County Clinics and the Life Extension Institute of New York.

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Aortoesophageal Fistula and Sentinel Hemorrhage

By Nalin M. Patel, M.D., Champaign and Wanchai S. Sangchantr, M.D., Chicago

Our patient had a third episode of upper gastrointestinal hemorrhage twelve months after gastroesophageal resection for adenocarcinoma of the stomach. An aortoesophageal fistula was suspected by endoscopy and confirmed by thoracotomy. Bleeding stopped after ligation of the fistula. To our knowledge, this is the first report of aortoesophageal fistula after surgery for adenocarcinoma of the fundus of stomach.

Aortoesophageal fistula is not an uncommon entity. Dubrueil described the first case in literature in 1818. Since then, many more cases have been reported.[1-3] The diagnosis is rarely made before surgery or autopsy. It has been suggested that esophagoscopy, angiography if possible, and thoracotomy be done immediately when the disorder is strongly suspected.[4] Despite an aggressive approach, few patients survive.[5]

Case Report

A 72-year old woman was admitted to the hospital because of hematemesis and melena. An upper gastrointestinal endoscopy revealed an ulcer at the lower end of the esophagus within the cardia of the stomach, and biopsies showed adenocarcinoma. A left thoracotomy was performed, the distal esophagus and proximal stomach were resected, and the esophageal and gastric remnants anastomosed. No radiation therapy was given.

Six months later bleeding recurred. Endoscopy showed evidence of esophagitis, and biopsies were negative for carcinoma. She did well for four months, but then returned with more severe bleeding. The anastomotic junction was again seen to be bleeding and biopsies did not reveal carcinoma. After a few days she was again discharged.

Finally, two months later, another acute hemorrhage occurred. Endoscopy revealed a site of active bleeding at the anastomotic junction. She underwent thoracotomy for a suspected aortoesophageal fistula. Her general condition did not allow an opportunity to perform an angiography. A 2-3mm. fistula arising directly from the aorta and entering the anastomotic junction was clamped and ligated. The bleeding was arrested. Although the patient had required 18 units of blood, she recovered and continued to do well for twelve months, when she died from metastatic cancer.

Discussion

Aortoesophageal fistula may occur due to erosion of aortic aneurysm, esophageal carcinoma and several other causes (Table 1). The pathogenesis of aortoesophageal fistula is believed to be necrosis caused by occlusion of the vasa vasorum by fibroblasts and neoplastic cells. Radiation therapy is also associated with small artery and arteriolar endothelial sloughing and fibrosis producing perforation.[12] Our patient did not receive any therapy. However, after her thoracotomy, traumatic occlusion of the vasa vasorum and fibroblast proliferation may have caused her to form a fistula. Hence, ligation of the fistula arrested bleeding. During each bleeding episode, a recurrent cancer was suspected but this was not present and multiple biopsies were negative for malignancy. A year after first admission, the patient developed metastatic cancer and expired.

Symptoms may include mid-thoracic pain, sentinel arterial hemorrhage, the so-called "signal hemorrhage" and final exsanguination after a symptom-free interval (Chiari's triad). Sentinel hemor-

Table 1.
Causes of Aortoesophageal Fistula

1. Erosion of aortic aneurysm[6,7]
2. Esophageal carcinoma[8]
3. Impaction of foreign body in esophagus
4. Operations for aortic aneurysm[9]
5. Coarctation
6. Vascular rings
7. Patent ductus arteriosus
8. Aortic resection
9. Mediastinal infections
10. Severe chest trauma
11. Syphlitic aortitis
12. Esophageal ulceration
13. Corrosive esophagitis[10,11]
14. Achalasia

rhage is a warning symptom which is usually hours, days or weeks apart from the final serious exsanguination. As in our patient, the episodes may be months apart.

Carter, *et al.*,[13] emphasize the necessity of an aggressive approach to diagnosis and therapy in patients with aortoesophageal fistula. The most important factor in diagnosis is an awareness of the possibility of an aortoesophageal fistula and Chiari's triad. Esophagography is generally not useful. Esophagoscopy is more definitive and may show a tiny fistula with oozing blood, which points to the strong possibility of an aortoesophageal fistula. Aortography would be diagnostic, although immediate thoracotomy is not only the ultimate diagnostic procedure but it offers the patient the possibility of lifesaving control of hemorrhage and repair of the fistula. In discussion, those authors include the only successful resection of an aortoesophageal fistula following a surgery for a vascular ring anomaly and encourage more reports. ◀

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Testicular Tumors in Cryptorchidism

By Wagih M. Shehata, M.D., F.F.R./Cincinnati

Cryptorchidism is not uncommon. It has been reported in 2.7% of full-term infants, 0.3% of adults and up to 21% of premature infants.[1-3] Ectopic testis, however, is rare (one in 25,000).[4] Orchiopexy is recommended at around age two[5] to preserve fertility, avoid emotional trauma and prevent the development of cancer[1,6] which is 8-50 times higher in this group than in normal males.[3,6,7] The risk of malignant transformation is five times more common when the testicles are in the abdomen rather than in the inguinal area[6] and 15% of such testicular cancers are bilateral.[3] Information about the role of radiation therapy following the resection of malignant testicular tumors in cryptorchidism is scarce.[1,8]

From May 1963 until May 1974, ten patients underwent orchiectomy for undescended testicles at our facility. During the same period of time, a total of 19 patients had orchiectomy in the same hospital for carcinoma. Three of these patients (16%) are the subjects of this report involving undescended testicles. In one of the three, the involved testicle was in the abdomen and whole abdominal irradiation was required.

Case 1

A forty-three year old Caucasian male was admitted with the chief complaint of pain in the right iliac fossa. He had undergone right inguinal hernia repair 25 years earlier. At that time the right testicle had been found to be in the right iliac fossa and could not be brought down to the scrotum.

On palpation, the left testicle was normal. There was a mass about 4 cm. in diameter located above the medial end of the right inguinal ligament. Chest radiographs and excretory urogram were within normal limits. CBC was unremarkable apart from a relative polycythemia. Patient underwent right orchiectomy. The right testicle, which measured 6.5 × 5 × 6.5cm., was found to be involved by pure seminomatous tumor with areas of hemorrhage and necrosis. The patient then received 3500rad in 3½ weeks utilizing two parallel-opposed, anterior-posterior cobalt 60 ports covering the right groin, right pelvis and paraortic area. Patient is well and free of disease ten years after therapy.

Case 2

A 26 year old Caucasian male presented with pain in the right groin during walking. He had a history of bilateral cryptorchidism. Attempts at orchiopexy in his childhood had failed to deliver the testicles to the scrotum. The procedure ended by left orchiectomy and the right testicle was not removed as it was adherent to a subcutaneous pouch in the right inguinal area.

Physical examination revealed enlargement of the right testicle which was over the right inguinal area. Chest radiographs, liver enzymes and excretory urogram were normal except that the right kidney was at the level of the fourth and fifth lumbar vertebrae. Patient underwent right radical orchiectomy and the specimen was found to contain a 6 × 4 × 4cm. pure seminomatous mass. The epididymis was not involved by the tumor.

The patient subsequently received a dose of 3000 rad in three weeks utilizing two parallel-opposed, anterior-posterior cobalt 60 ports covering the right groin, right pelvis and paraortic area. The patient remained free of disease for five years following therapy after which he was lost to follow-up.

Case 3

A 35 year old Caucasian male presented with left lower abdominal pain for a few months' duration and undescended left testicle since birth. Physical examination was unremarkable apart from absence of the left testicle. Excretory urogram revealed lateral deviation of the middle third of the left ureter. At laparotomy, a 10cm. tumorous mass was found to be attached to the posterior abdominal wall situated opposite the left lower paraortic area. Histological examination

of the resected mass revealed undescended testis involved with pure seminoma. Patient received whole abdominal and pelvic irradiation (cobalt 60) for a tumor dose of 3000rad in four weeks with kidney shielding posteriorly. Patient then received a boost of 600rad by three additional daily treatments to the tumor bed area, which was demarcated by metal surgical clips. Treatment was well tolerated and was not associated with any long term complications. Patient remained free of disease on follow-up ten years after his therapy.

Discussion

The testis could be absent from the scrotum by deflection in the suprapubic inguinal pouch or could be truly undescended by remaining in the normal path of descent while failing to reach the scrotum.[3] The above conditions should be differentiated from a retractile testis, which is common in infants. A retractile testis has to be observed at least once in the scrotum.[3] An undescended testis could be located in the abdomen, inguinal canal or between the external inguinal ring and the neck of the scrotum.[3] Familial tendency has been observed in 5.5% of the cases.[5] Undescended testicles are frequently associated with other anomalies such as inguinal hernias and endocrine changes.[5]

Early hormonal therapy (chorionic gonadotrophins) could be effective in 33% of bilateral and 16% of unilateral undescended testicles.[3] The recent trend is to recommend a timely orchiopexy by age two[5] rather than by age five[3] as in the past. This is due to the fact that all ectopic testes do not grow beyond the resting stage, with loss of fertility in 64% of boys 11-15 years of age in the other descended testicle.[5] Therefore, it is recommended to perform an orchiectomy for an ectopic testicle rather than orchiopexy.[9] Successful orchiopexy depends upon an initial normal testis (only 40% by biopsy are mature), adequate size of the scrotum, adequate mobilization of blood supply and repair of associated hernia.[10] The risk of malignant degeneration in an ectopic testicle is 18 times that of a normal gland.[5] Therefore, routine exploration and extirpation are justified. Surgical risks might outweigh benefits in preventing cancerous changes in elderly patients.[5] The incidence of testicular cancer in the general male population is only 2.1 per million per year.[3] Patients with cryptorchidism with testis descended late (after age 20) should be checked periodically to rule out malignant changes.[1] Tumor development seems to be independent of testis site or correction of cryptorchidism after age two.[1]

Batata, *et al.*[1] reported 137 patients with testicular cancer in cryptorchids (corrected or uncorrected) from a total of 1152 patients with testicular cancer (12%). Out of these 137 patients, 56 had pure seminoma, 41 embryonal, 37 teratocarcinoma and three pure choriocarcinoma. Their peak incidence was in the third and fourth decades (regardless of the site) which was similar to testicular cancer in non-cryptorchidism.[1] Correction of cryptorchidism had no effect on initial cancer stages or five year survival.[1] The frequency of malignant germinoma, other than pure seminoma, increased with the level of descent of cryptorchid testis.[1]

Our three reported cases demonstrate the curative therapy of surgery and radiation in testicular seminomas arising in cryptorchidism. Our third case, in particular, represents the role of whole abdominal irradiation[11] in adequately sterilizing microscopic residual disease at the tumor bed, possible extensions to the draining lymph node area and/or omentum. The five year survival in pure seminoma patients is 79% as compared to 50% for germinal carcinoma.[1] The recommended radiation dose is 2500-3000 rad in three to four weeks for pure seminoma and 4000-5500 rad in five to six weeks for germinal carcinoma.[1,4] Prognosis mainly depends upon the stage and type of malignancy.[1]

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Viewbox

(Continued from page 27)

Diagnosis: Perinephric Abscess

Neither the long history nor the plain film are compatible with an acute sigmoid volvulus, where typically, a dilated, inverted U-shaped loop of gas-distended sigmoid colon occupies a major part of the abdomen. Gastric bezoars conform to the shape of the stomach, which this collection fails to do. Pancreatic pseudocysts are seldom visible on plain radiographs unless they are large. The plain film findings include displacement of gastric or intestinal gas, a soft tissue mass, or calcification in a cyst wall. An infected pseudocyst could present with gas bubbles and would also be a remote possibility in this case.

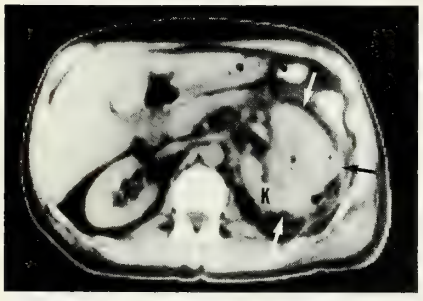


Figure 2—CT scan at level of the kidneys. A mass (arrows) lateral to the left kidney (K) contains gas bubbles identifying it as a perinephric abscess.



Figure 3—Barium enema, lateral view. There is thickening and irregularity of the mucosa (arrows) of the ascending colon due to a perinephric abscess which has extended to the colon. The patient also had an IVP and the ureter is displaced ventrally (arrow heads). The patient presented with diarrhea and fever.

The clinical history and findings of retroperitoneal gas make perinephric abscess the best diagnosis. The mottled lucencies in the left side of the abdomen are gas collections located in the perirenal space as seen on the CT examination (Figure 2) in this patient.

Pathogenesis

A perinephric abscess is a collection of pus in the space between the kidney and the surrounding renal fascia. Most perinephric abscesses originate when a renal parenchymal abscess ruptures into the perinephric space. Hematogenous spread of infection, direct spread of infection from adjacent inflammatory processes such as appendicitis, diverticulitis, prostatitis, liver or gallbladder abscesses, and pelvic inflammatory diseases are other causes of perinephric abscess.[1,2] Predisposing factors include diabetes, obstructive uropathy, inflammatory disease at other sites, polycystic kidney disease, trauma, and intravenous drug abuse.[1,3]

The perinephric abscess is usually contained within Gerota's fascia. However, just as adjacent inflammatory processes can spread to the perinephric space, so can perinephric processes extend into other regions.

In a series of 160 patients with retroperitoneal abscesses, 43% were perinephric. Of these perinephric abscesses, 70% were of renal origin and 25% had no known etiology. Abscesses in the pararenal space are most often due to direct extension from adjacent structures.[4] Posteriorly, the abscess can invade the psoas muscle. Inferiorly, extension into the perivesicular area can occur. Both the colon and peritoneum can be involved (Figure 3).[1,5,6]

Previously, most infections were caused by gram positive organisms. Currently, gram negative organisms, the most common urinary tract pathogens, are usually the causative organisms.[1,3]

Clinical Presentation

Patients often present with nonspecific symptomatology, making perinephric abscess a diagnostic problem. Symptoms can continue for weeks to months. Patients frequently complain of fever and flank or abdominal pain.[1,3,5] Less common symptoms include pain referred to another area, chills, dysuria, nausea, vomiting, weight loss, and weakness.[1,3]

Physical signs are flank tenderness, elevated temperature, and at times a flank or abdominal mass.[1,2] Laboratory examination usually reveals a leukocytosis. Anemia and azotemia may occur. An abnormal urinalysis is found in 25-30% of patients.[1]

Radiographic Findings

Before the advent of CT and ultrasound, plain film radiography and intravenous urography were the examinations of choice in the evaluation of perinephric processes. CT and ultrasound now provide an axial view of the kidneys and are much more sensitive and specific than radiographic studies.

The kidney is seen on plain films because it is surrounded by perirenal fat within Gerota's fascia. When pus is in the perirenal space, the kidney is no longer so well defined, and its margins are blurred. Occasionally, a soft tissue perirenal mass can be visualized. When the kidney is involved by an inflammatory process, it may become fixed in position, so that on upright and recumbent radiographs it will not change its location. Because of muscular splinting, there can be scoliosis, concave to the side of the perinephric abscess. Also, the psoas muscle shadow can be obliterated. When gas forming bacteria are present, lucencies due to gas in the perirenal space can be detected, as in the patient presented here (Figures 1,4).[1,3,4]

Intravenous urography may reveal a mass with compression of the calyces in the region of the mass. Tomography can show loss of definition of the kidney outline. The kidney can be displaced both later-

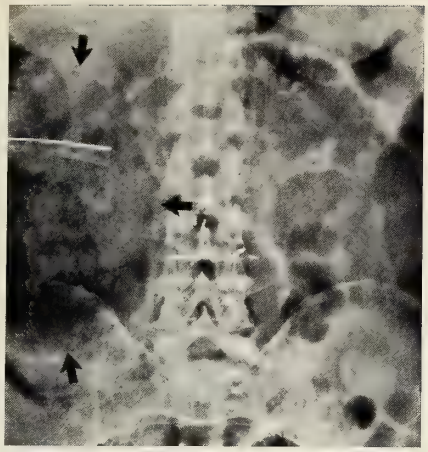


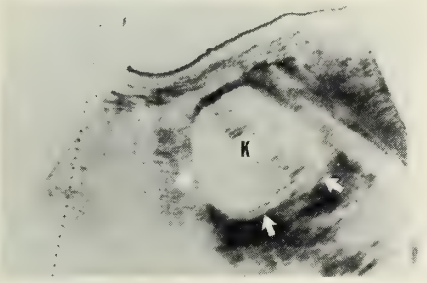
Figure 4—Supine abdomen. Mottled lucencies due to right perinephric abscess (arrows) represent gas collections within the perirenal space.

ally and anteriorly, and the course of the ureter may deviate, depending on the location of the abscess. The signs described in both plain film radiography and intravenous urography are nonspecific. Some may be present in normal patients while others may not be present in those with perinephric abscesses.[1,3,4]

Gallium 67 imaging may serve as an adjunct to diagnostic radiologic procedures for the evaluation of perinephric processes. When performed with special attention to the renal areas, GA-67 imaging can be used to assess inflammatory or malignant conditions affecting the kidney.[4,7]

The most specific studies for evaluating the perinrenal space are ultrasound and CT. Ultrasound examination may reveal a complex mass within or outside the renal cortex, which can displace the kidney (Figure 5). When gas is present within the abscess, there may be highly echogenic areas.[2,3,5,6]

Figure 5—Longitudinal ultrasound study of the right kidney (K). There is a large perirenal abscess (arrows) of mixed echogenicity.



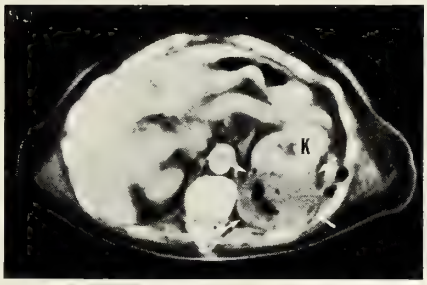


Figure 6—CT scan at the level of the kidneys. The left kidney (K) is displaced ventrally by a mass (arrows) which contains gas bubbles. The abscess also involves the posterior pararenal space.

CT imaging shows the perirenal (Figures 2,6) and pararenal spaces (Figure 6) well, provided the patient has a normal or large amount of body fat. Signs of abscess include a mass of low attenuation which occupies the perinephric space or extends into surrounding structures. The perinephric abscess can also displace the kidney. As in ultrasound, if gas forming bacteria are present, the gas can be detected (Figures 2,6).[2,3,6]

Treatment

Drainage is the therapy of choice for a perinephric abscess and can be performed surgically, or under CT or ultrasound guidance.[5,8]

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Abstracts of Board Actions

(Continued from page 12)

BENEFITS OF UNIFIED MEMBERSHIP

Based upon information provided by the AMA Board of Trustees, the ISMS Board was informed of recommendations to be reported to the AMA House of Delegates at the 1984 Interim Meeting. Included in the recommendations will be the following:

- The AMA will establish an "ombudsman" for representation and liaison from unified societies. This should allow more direct contact with the AMA by members of unified societies.
- A 10% discount on dues in 1985 will be available to members of unified societies who are in their first year in practice, their second year in practice, or who are full dues-paying members.
- Reimbursement for collection of AMA dues will be increased for unified societies, one percentage point higher than for those societies collecting AMA dues when the society is not unified.
- The AMA will provide unified societies staff services for special projects which are mutually agreeable to the unified societies and the AMA.
- A new Unified Societies Advisory Committee to the AMA will be formed including representatives from all unified societies.
- Beginning in 1985 a special briefing will be provided by the AMA for officers of unified societies.
- Benefits accruing to unified societies will be identified to all members of unified medical societies and, in addition, non-unified societies will be encouraged to become unified.

PROFESSIONAL LIABILITY INITIATIVE

An extensive report was presented by Burson & Marsteller pertaining to activities being developed for the Professional Liability Initiative. There was extensive review of the basic document, as well as guidelines for organizing physician activity. Broad discussion was held pertaining to the necessity of building credibility with third parties, such as other professional groups, Chambers of Commerce, service clubs, and industry. It was agreed that items targeted to specific publics might be preferable to a mass media campaign. Consequently, the Board approved those public relations proposals presented for targeted local third party credibility and consistent with currently authorized funding, but that development of any broad public appeal through purchase of media time or production of films be deferred. Further, it was agreed that there would be continued exploration of audio-visual mechanisms to educate the various publics on specific professional liability concepts. The Executive Committee was directed to explore the necessity and feasibility of developing additional funding from the membership to support the Professional Liability Initiative.

DRUGS AND THERAPEUTICS

The Board approved the following drug products for inclusion in the IDPA Drug Manual: Augmentin (Amoxicillin Trihydrate; Potassium Clavulanate) Tab 250mg; 125mg, 500mg; 125mg, Susp 125mg; 31.25mg/5ml, Susp 250mg; 62.5mg/5ml; Trandate (Labetalol HCl) tab 200mg; Normodyne (Labetalol HCl) tab 300mg and Brethaire (Terbutaline Sulfate) 0.20mg/actuation, and 75mg/unit.

The Board also recommended that the following drugs not be included in the IDPA Drug Manual: Nitro-Tsar (Nitroglycerin); X-Prep Bowel Evacuant Kit and X-Prep Bowel Evacuant Kit-2 (X-Prep Liq.), (Senokot-S tabs 2), (Rectolax supp), and (Citralax gran 30gm); Actifed with Codeine Syrup (Codeine phosphate; Pseudoephedrine HCl); Lotrisone (Betamethasone Dipropionate; Clotrimazole) and Inocor (Amrinone Lactate).

The Board further recommended that: (1) Flurazepam (Dalmane) 15mg tablet be retained in the IDPA Drug Manual; and (2) Dalmane 30mg tablet not be included in the IDPA Drug Manual.

OTHER ACTIONS

In addressing various other issues, the Board:

- Accepted the Financial Statements for the period ended August 31, 1984; October 26, 1984, IMPAC Collection Data Report; and October 15, 1984, Membership Dues Payment Report.

- Approved requests for Changes in Membership Status with the deletion of Dr. Melinda Uhrich, Decatur, Macon County Medical Society, Seventh District, from exempt status.
- Referred a proposed resolution on organ transplantation for the AMA 1984 Interim Meeting to the ISMS AMA Delegation.
- Referred an AMA resolution developed by the Oklahoma State Medical Association, calling for a national media campaign to enhance the image of the medical profession, to the ISMS AMA Delegation.
- Agreed to assist the Auxiliary and Medical Student Section in constructing an Impaired Panel within their organizations; offered consultation and expertise for such groups through members of the ISMS Impaired Physician Panel; and recommended that the Medical Student Section pursue the possibility of establishing Panels on Impairment through their medical schools.
- Referred to legal counsel for further investigation the question of adding finance charges to a patient's unpaid bill for medical services.
- Approved an Unfinished Business Report pertaining to retired members, reduced and waived dues (Res. 1, 17, 18 A-84) for the 1985 Annual Meeting.
- Approved an Unfinished Business Report entitled, "Insanity As A Defense," (Res. 20A-84) to be submitted to the 1985 Annual Meeting.
- Approved Guidelines for Physician/Attorney Relationships, contingent upon approval of the Illinois State Bar Association Board. If approved by the ISBA, agreed to disseminate information to all county societies and to publish the Guidelines in the *Illinois Medical Journal.*
- Agreed to submit to the 1985 HOD a resolution urging deletion of the ISMS policy statement on "Advertising." Also agreed to include the Illinois law on physician advertising, along with any modifications in that statute or rules, in all future *Illinois Medical Journal* reference issues.
- Approved an expenditure of up to $2,000 to research issues associated with determining the legal status of medical staffs in Illinois.
- Accepted for submission to the 1985 ISMS House of Delegates, three policy statement resolutions entitled, *Blood Availability, Smoking* and *Surgery, Reconstructive.*
- Agreed to support the concept that physicians should provide information on sexual abuse, infectious diseases and day care centers to patients who have children.
- Approved the development of a Sports Medicine Program to be held at the 1985 Midwest Clinical Conference.
- Approved investigation of an annual ISMS Sports Day to be held in mid-1985, with a report on financial and program aspects to be submitted at the January Board meeting.
- Agreed to annually review and approve appointments to the ISMS Committee on Hospital Medical Staffs at the September Board of Trustees meeting.
- Agreed to consider allotting time for discussion of hospital medical staff issues at the 1985 ISMS Leadership Conference.
- Discharged the Task Force on Health Professions and transferred its functions to appropriate councils and committees. Consequently, an action recommended by the Task Force which asked Board approval for co-sponsorship of an Educational Program with the Illinois Joint Practice Committee was referred to the Committee on Hospital Medical Staffs.

APPOINTMENTS/NOMINATIONS

Acting on recommendations of the Councils and Executive Committee, the Board:

- Agreed to invite the IDMH/DD Associate Director of Clinical Services to serve as a consultant to the Council on Mental Health & Addiction.
- Ratified the following nominations:
 Drs. Earl Frederick, Jesus Vega, Richard Webb, Ronald Welch and Robert Hamilton, to the Attorney General's Task Force on Medicaid Fraud.
 Drs. Fred Z. White, Irwin Smith, Brent Horsley, ISMIE; Warren D. Tuttle, Phillip Boren, Jerry Ingalls, ISMIS; and Alfred Clementi, George Burke, Harold Jensen, ISMS; to the Task Force on Channeling and Alternative Delivery Systems.
 Drs. Marvin Rosner, Chairman; Carl Mattioda, member and Leo Wrona alternate Second District; Cynthia Fraed, member and Allan Bennett alternate Ninth District; Committee on Maternal Welfare.
 Drs. Glen Pittman, member and Harold Jensen, trustee, Panel on Impaired Physician.
 Dr. Allan Lorincz, Committee on Drugs & Therapeutics.
 Drs. Jeffrey Grabenstein and A. William Schafer, Joint Practice Committee.
 Dr. Robert P. Johnson to the ICCME Nominating Committee to develop a slate of candidates for the ICCME Board.

INFORMATIONAL ITEMS

The Executive Administrator reported on the Professional Liability Initiative, a legal counsel opinion regarding the Educational and Scientific Foundation's Student Loan Fund, Governor's Task Force on Medical Professional Liability and the new Headquarters Office.

NEXT MEETING

The Board set the next Board of Trustees meeting for January 12-13, 1985, at ISMS Headquarters. ◀

ISMSA Works to Combat Substance Abuse

By Laura Hays (Philip)/Kankakee

Ask a group of American parents what they fear most for their children and you will find drug and alcohol abuse mentioned over and over. Law enforcement agencies, hospitals, treatment centers, educators and young persons themselves can verify that substance abuse is common, devastating and affecting our entire society.

Many experts feel that young people get started on drugs and alcohol because of low self-esteem and poor communication skills. Our young people are simply afraid of being rejected by their peers if they say "no."

A program to help develop self-esteem and communication skills started by the Kankakee County Medical Society Auxiliary has been a resounding success. This two day seminar geared to sixth graders has received praise and publicity in the local press and participating auxilians have felt themselves grow as they reach out to our youth.

The program, called "Let's Talk," begins with a slide presentation which gives basic drug facts and shows how the media promote drugs and alcohol. The slides also explain alternatives to depending on substances and detail community resources for those with abuse problems. The second day, the auxilians work on developing communication skills through role-playing and other techniques.

Begun in 1983 by Val Schuller (Reinhold), "Let's Talk" has been presented in 60% of the sixth grade classrooms in Kankakee County. Herself a teacher and parent, Val chose the "Let's Talk" approach from the American Medical Association Auxiliary Project Bank catalog. The program is adapted from a similar one from Pima County, Arizona. An intensive training course was set up for auxilians and the program debuted during the 1983-84 school year with five auxilians speaking to over 1000 students. Two new recruits will begin visiting classrooms this month.

These seven hard working women are a diverse group of individuals who became close friends as they united for this project. Several participants say they have gained self-confidence and poise through giving the seminars. They all feel that if their work has helped even *one* young person avoid a drug problem, it has been worthwhile.

Other Illinois county auxiliaries have also been active in the substance abuse area. St. Clair County joined a community task force formed as a result of media attention during the appearance of Nancy Reagan's "Chemical People" documentaries. This task force also came to the conclusion that low self-esteem resulted in teenage substance abuse and began a series of seminars for high school girls to build self-esteem and confidence through exercise classes, skin-care instruction and nutrition information.

The Adams County Medical Society Auxiliary coordinated a drug and alcohol program with the Quincy Junior High School in the fall of 1983 and spring of 1984. The goal was "Prevention through Education." This was accomplished by presenting new research findings on drug and alcohol use and enough concrete information to take the thrill and mystique out of its use. Dr. Richard L. Newman, psychiatrist, and his staff, along with the police liaison officer, presented the two-day program. The first day consisted of education in alcohol use, abuse and drunk driving. The effects of marijuana and other drugs were covered on the second day. A mixed media approach was used, featuring a short film, a lecture and a question and answer period.

An evening seminar on "Positive Parenting" for parents and families was held. It was open to the public without charge and attracted over 400! The main topic of the program was the early identification of the high-risk child. A well-received question and answer period followed.

Illinois auxiliary members care about the youth of our country. We want them to feel good about themselves, be able to articulate their feelings and needs, and remain drug-free, healthy and strong. ◀

MECO

By Lauren Baker, Chicago/MECO Project Director

As the "match" (for residencies) approaches, first and second year medical students may think they still have a while to choose a field of medicine. Third year medical students find that this decision looms close, although they have yet to complete core clerkships. Some students may know what type of medicine they want to practice by the summer of their senior year. Others (myself included) may feel it is too early to decide.

MECO (Medical Education-Community Orientation), a summer program which exposes student externs to many fields of medicine, may better prepare some students to make informed decisions about their medical career.

MECO is sponsored by the Illinois State Medical Society's Medical Student Section and the American Medical Student Association. The program offers the student early clinical exposure and introduces him/her to the practice of medicine in a community setting. MECO, depending upon the state, is either a hospital centered program (as in Illinois), a physician based program (as in North Dakoka) or a combination of these two approaches (as in Kentucky).

In the hospital orientation, MECO is developed around the concept of mini-clerkships; the student rotates through hospital departments (*e.g.*, surgery, pediatrics, medicine). Examples of opportunities are the ability to make rounds with physicians, assist in the OR or delivery rooms, and do histories and physicals.

Students participate in community programs (*e.g.*, nursing homes, drug rehabilitation centers, planned parenthood organizations, ambulance services). MECO basically offers the student a clinical orientation that is not available within the traditional medical curriculum.

Since its 1968 inception, more than 4,000 students in 35 states have participated in MECO. The goals and objectives are multi faceted. By introducing students early in their medical education to primary care medicine in a community atmosphere, and to the cultural, economic and environmental determinants of health, it is hoped that it will raise their awareness of the grave need for physicians in underserved areas and the increasing demand in general for quality, community oriented, primary care medicine. Additional goals of MECO are the following:

- To introduce the student to the operation and organization of community health care institutions and their inter-relationships with the delivery of health care in a community.
- To introduce the student to the roles of other health care professionals and the interplay between these individuals and their fellow physicians.
- To introduce the preclinical medical student to the clinical aspects of medicine, smoothing the transition from the classroom to the clinics.
- To provide the student with an opportunity to take an active part in the planning of his own educational experience.
- To provide the student with some insight into the field of medicine he or she would like to practice.
- To introduce the student to the multiple opportunities for continuing medical education and practice in a non-academic setting.

MECO also affords numerous advantages to the local community and participating hospital and/or physician(s). Studies have shown that a statistically significant number of students reported either returning or stating they would return to the locale of their MECO program. For many physicians a major appeal of the program is the satisfaction gained through participation in the medical education of future physicians and the stimulation provided by the student's presence.

ISMS is always searching for additional hospitals and physicians wishing to participate in the MECO program. Community hospitals that are not primary university teaching hospitals, community physicians and group practice clinics are ideally suited.

In general, students receive an educational stipend of at least $100 per week and possibly room and board. This funding is provided by the hospital where the student is based.

MECO in Illinois is co-sponsored by the ISMS Medical Student Section, the Illinois Hospital Association, the Illinois Academy of Family Physicians and the American Medical Student Association. For further information, please contact MECO Project Director, Illinois State Medical Society, Twenty North Michigan Ave., Chicago 60602. ◀

DOCTOR'S NEWS

RESOLUTIONS DEADLINE

The ISMS House of Delegates annual meeting will convene April 24-27 at the Marriott O'Hare Hotel. Resolutions for House of Delegates consideration must be *received* in the ISMS offices by March 22. Those received after that date will be considered late resolutions and will need approval by a special committee prior to acceptance.

Resolutions will be published in the March *IMJ* by author and subject. However, only those resolutions received in the ISMS offices by an earlier deadline, February 20, can be published.

PHYSICIANS IN THE NEWS

Former ISMS President **Leo P.A. Sweeney, M.D.,** Evergreen Park, has been elected secretary/treasurer of the Chicago-based Fifty-Year-Club of American Medicine. Dr. Sweeney has served as a trustee for both ISMS and the Chicago Medical Society.

Shirley Ann Roy, M.D., has been named a fellow of the American College of Physicians. Dr. Roy is on staff at Weiss Memorial, Cook County, Edgewater and Thorek hospitals in Chicago.

Dr. Olga Jonasson, Chicago, was elected president of the Council of Medical Specialty Societies (CMSS) at the Council's November 20 annual meeting. Chief of surgery at Cook County Hospital, Dr. Jonasson received her M.D. degree from the University of Illinois College of Medicine where she currently is a professor of surgery. CMSS is composed of representatives from each of the major medical specialty societies representing the diplomates of primary or conjoint examining boards recognized by the American Board of Medical Specialties.

Dr. Arthur A. Rodriquez, director of the physical medicine and rehabilitation department at Christ Hospital, Oak Lawn, was presented with the Recognition Award for Distinguished Clinicians from the American Academy of Physical Medicine and Rehabilitation. Dr. Rodriquez, who was one of only three winners of this year's national award, received the honor at the annual assembly of the Academy on October 23.

Dr. Sidney Levitsky, Kenilworth, has been named a corresponding member of the Board of the Polish Association of Surgeons. Dr. Levitsky, chief of the cardiothoracic surgery division at the University of Illinois, also serves as the 1984 steering committee chairman of the American College of Chest Physicians' Section of Cardiovascular Surgery and was recently installed as president of the Chicago Heart Association.

Dr. Bernard Sigel, Chicago, was elected a governor of the American Institute of Ultrasound. Chief of the surgical bioengineering section in the University of Illinois Department of Surgery, Dr. Sigel's term as governor continues until 1987.

Dr. Philip Donahue, Chicago, has been named to the editorial board of *Digestive Surgery,* a new international journal for surgeons concerned with diseases of the alimentary tract. Dr. Donahue, chief of general surgery at the Veterans Administration West Side Hospital, also was elected a member of the American Gastroenterological Association.

ILLINOIS PHYSICIANS HONORED BY AMERICAN ACADEMY OF OPHTHALMOLOGY

Nine Illinois physicians were recently honored by the American Academy of Ophthalmology for their contributions to medical education. They are: **Drs. Joseph E. Alfano, Gerald A. Fishman, Manus C. Kraff, Peter H. Morse, Joel Sugar, Elise Torczynski, Ramesh C. Tripathi, and Galdino E. Valvassori,** of Chicago; and **Howard H. Tessler,** of Waukegan. The awards were presented in opening ceremonies of the Academy's annual meeting, November 11-15 at the Georgia World Congress Center, Atlanta.

GOVERNOR PROCLAIMS JANUARY EYE HEALTH MONTH AT ILLINOIS ASSOCIATION OF OPHTHALMOLOGY REQUEST

At the request of the Illinois Association of Ophthalmology, (IAO) Illinois Governor James R. Thompson proclaimed January "Eye Health Month." Through the Governor's proclamation and an accompanying public education effort, IAO is hoping to reduce the number of people who suffer preventable blindness. The National Society to Prevent Blindness asserts that 50% of all blindness can be prevented.

PHYSICIAN VISITS ON THE DECLINE

The AMA Center for Health Policy Research reported that utilization of physician services declined slightly from 1982 through the first half of 1984. The decline was evident in all visits to physicians, including those in office settings, hospital rounds, and emergency room and other hospital outpatient treatment. The AMA research center predicted that if the trend continues, competitive pressures can be expected to increase as the market tightens.

TAPES OF ISMS-SPONSORED PPO SEMINAR AVAILABLE

Cassette tapes of an Illinois State Medical Society-sponsored seminar on preferred provider organizations and contracting for arrangements for physician services are now available. The cassettes are condensed versions of the seminar presentations and are available for a cost of $10.

Orders should be directed to ISMS Cassettes, Teach 'Em, Inc., 160 E. Illinois St., Chicago, IL 60611, (312) 467-0424.

More than 700 physicians attended the PPO seminar, which was held in Chicago and Springfield in October. The seminars provided physicians with insight into issues surrounding selective contracting arrangements and informed them of the questions they should be asking before entering into such arrangements.

Legislation which would allow PPOs to operate under the Illinois Insurance Code is expected to be introduced in the General Assembly during its spring session.

FOOD REACTION BOOK AVAILABLE

Adverse Reactions to Foods, a 321-page book produced jointly by the American Academy of Allergy and Immunology and the National Institute of Allergy and Infectious Diseases, is now available from the U.S. Government Printing Office, Washington D.C., 20402. The book covers such topics as chemistry of selected food antigens, the fate of food antigens in the digestive tract, immunologic and nonimmunologic food reactions, diagnosis and treatment of adverse food responses, and avoidance of specific foods—prior to known sensitization—in potentially susceptible infants. Copies of the book (Stock No. 017-044-00045-1) are $9.50.

INTERNATIONAL ACADEMY OF PATHOLOGY TO HOLD MEETING

The Annual Meeting of the U.S.-Canadian Division of the International Academy of Pathology will be held in Toronto, Ontario, Mar. 11-15. Scientific papers, poster sessions, specialty conferences and 45 short courses are scheduled in addition to two special courses. Further information may be obtained from Dr. Nathan Kaufman, 1003 Chafee Ave., Augusta, GA 30904, (404) 724-2973. ◀

GRADUATE TRAINING IN MATERNAL & CHILD HEALTH

The Graduate School of Public Health, San Diego State University, offers a nine month, full time educational program which terminates with a master of public health degree, majoring in maternal and child health. Also offered is a 21-month "Training Program in Handicapped Children and Youth" for pediatricians. This program combines clinical and community training and offers eligibility for certification by the American Board of Preventive Medicine. Applications for the August, 1985, term may be directed to Helen M. Wallace, M.D., M.P.H., professor and head, Division of Maternal and Child Health, Graduate School of Public Health, San Diego State University, San Diego CA 82182.

GET WELL WISHES FOR ISMS MEMBERS

The Illinois State Medical Society, concerned about members who become ill, would like to establish a mechanism to extend get well wishes. Persons who know of a member who is not well and might appreciate a greeting from the Society are encouraged to advise the division of membership in the ISMS offices: Twenty North Michigan Avenue, Suite 700, Chicago IL 60602; (312-782-1654).

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

FEBRUARY

Allergy

Regional Concept of Botany of Midwest
For: Allergists. Lecture and case presentations, February 17, Chicago. **Sponsor:** Illinois Society of Allergy & Clinical Immunology, 800 East Northwest Highway, Suite 101, Mount Prospect, 60056. **Fee:** TBD. **Reg. Limit:** None. **Credit:** Category 1, 5 hrs. **Contact:** Diane K. Kubis. **Phone:** 312-255-1024.

General Medicine

Medical Seminar-at-Sea
For: MDs, Surgeons. Seminar, February 15-March 3, Panama Trans-Canal Cruise. **Sponsor:** Southern Illinois University School of Medicine, Post Office Box 3926, Springfield, 62708. **Fee:** $600. **Reg. Limit:** TBD. **Credit:** Category 1, 66 hrs. **Contact:** Charles Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** 217-782-7711.

Advances in Family Medicine
For: MDs. Lecture, February 11-15, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, 60612. **Fee:** $500. **Reg. Limit:** 90. **Credit:** Category 1, 35 hrs. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** 800-621-4649 in Illinois; 800-621-4651 outside Illinois.

Alzheimer's Disease: Diagnosis, Treatment and Management; Innovative Approaches for the Health Care Team
For: Physicians, Staff. Symposium, February 12, 8:30-4:00 PM., Chicago. **Sponsor:** Johnston R. Bowman Health Center for the Elderly, Rush-Presbyterian-St. Luke's Medical Center, 710 S. Paulina, Chicago. **Fee:** $65.00. **Reg. Limit:** 150. **Credit:** Category 1, 5 hrs. **Contact:** Karen Tertell. **Phone:** 312-942-7014.

Neurology

The Biologic Basis of Neurology and Psychiatry
For: Neurologists, Psychiatrists. Lecture, February 25-March 1, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, 60612. **Fee:** $570. **Reg. Limit:** 90. **Credit:** Category 1, 42 hrs. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** 800-621-4649 in Illinois; 800-621-4651 outside Illinois.

Pathology

The Pathologist's Role as a Clinical Consultant in Laboratory Medicine
For: Pathologists. Lecture, February 11, Chicago. **Sponsor:** Chicago Pathology Society, Loretto Hospital, 645 South Central Avenue, Chicago, 60644-9987. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hrs. **Contact:** Marshall H. Short, M.D. **Phone:** 312-626-4300, Ext. 5720.

Surgery

Review Course in Neurological Surgery
For: Neurosurgeons, Neurologists. Lecture, February 1-10, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, 60612. **Fee:** $750. **Reg. Limit:** None. **Credit:** Category 1, 101 hrs. **Contact:** Robert J. Baker, Dean. **Phone:** 800-621-4649 in Illinois; 800-621-4651 outside Illinois.

Fiberoptic Esophagogastric Endoscopy
For: Surgeons, Internists, Gastroenterologists. Lecture, February 25-27, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, 60612. **Fee:** $490.00 **Reg. Limit:** 15. **Credit:** Category 1, 16 hrs. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** 800-621-4649 in Illinois; 800-621-4651 outside Illinois.

MARCH

General Medicine

Medical Seminar-at-Sea
For: Physicians, Surgeons. Caribbean Cruise, March 3-11, 1985. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, Illinois 62708. **Fee:** $400.00. **Reg. Limit:** None. **Credit:** Category 1, 36 hours; AAFP, 36 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711.

Medicine

Infectious Disease Symposium
For: Physicians, Surgeons, Staff. Symposium, March 29, 1985, 1:00-5:20 p.m., Pinckneyville, Illinois. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, Illinois 62708. **Fee:** $45.00. **Reg. Limit:** None. **Credit:** Category 1, 4 hours. AAFP, 4 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711.

Inflammatory Bowel Disease
For: Physicians. Symposium, March 29, 1985, St. Louis, Missouri. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, Missouri. **Fee:** $100.00. **Reg. Limit:** 175. **Credit:** AAFP, 6 hrs; AMA Category 1, 6 hrs; AOA, 6 hrs. **Contact:** Loretta Giacoletto. **Phone:** (800)325-9862

Management of Childhood and Adolescent Skin Diseases
For: General Practitioners, Pediatricians. Lecture, March 18-20, 1985, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago. **Fee:** $380.00 **Reg. Limit:** 90. **Credit:** Category 1, 20 hrs. **Contact:** Robert J. Baker. **Phone:** (800)621-4649 in Illinois, (800)621-4651 outside Illinois

Ophthalmology

Ophthalmology Current Concepts Seminar '85
For: Ophthalmologists. Lectures, workshops, exhibits March 28-29, 1985 and optional March 30, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465B WARF Bldg, 610 Walnut Street, Madison, Wisconsin 53705. **Co-sponsor:** University of Wisconsin-Madison, School of Medicine, Department of Ophthalmology. **Fee:** TBD. **Reg. Limit:** None. **Credit:** Category 1, TBD; UW-Extension CEU's, TBD. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** 608-263-2856.

Psychiatry

Comprehensive Psychiatry Review Part II: The Psychiatric Interview
For: Psychiatrists. Course, March 8-10, 1985, Chicago, Illinois. **Sponsor:** The University of Chicago, 5841 South Maryland, Box 139, Chicago, Illinois 60637. **Fee:** $375.00. **Reg. Limit:** None. **Credit:** Category 1, 17 hrs. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056

Unique Seminars

The "Leadership" seminar assists the medical leadership in understanding the basic elements of effective CME planning. Participants will gain a foundation of skill in group techniques to involve medical staff members in CME planning and in how to start the systematic effort that leads to effective CME in the hospital setting.

The "Evaluation of CME Process" seminar provides the medical leadership with the practical information to apply the purposes of evaluation to program administration, faculty performance and participant learning. The leadership will discuss various common techniques used in the evaluation process for the development and implementation of quality CME programs.

For further information about participating in a unique ICCME seminar, please contact the Illinois State Medical Society, Twenty North Michigan Avenue, Chicago Illinois 60602 (312-782-1654).

Comprehensive Psychiatry Review Part I: Basic Considerations
For: Pathologists, Hematologists. Lecture, March 8, 1985, Illinois. **Sponsor:** The University of Chicago, 5841 South Maryland, Box 139, Chicago, Illinois 60637. **Fee:** $500.00. **Reg. Limit:** None. **Credit:** Category 1, 42 hrs. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056

Allergy
Lectures, March 1-3, 1985, Chicago, Illinois. **Sponsor:** Joint meeting with Chicago Medical Society, Midwest Clinical Conference. **For:** Allergists.

Pathology
Preleukemias and Myeloid Dysplastic Syndromes
For: Pathologists, Hematologists. Lecture, March 8, 1985, 7:00 PM., Drake Hotel, Chicago, Illinois. **Sponsor:** Chicago Pathology Society & Institute of Medicine of Chicago. **Co-sponsor:** Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hrs. **Contact:** Marshall H. Short. **Phone:** 312-626-4300 Ext. 5720.

Surgery
Industrial Injuries to the Hand
For: Physicians. Symposium, March 9, 1985, St. Louis Missouri. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, Missouri 63110. **Fee:** $100.00. **Reg. Limit:** 150. **Credit:** AAFP Prescribed, 6 hrs; AMA Category 1, 6 hrs; AOA, 6 hrs. **Contact:** Loretta Giacoletto. **Phone:** (800)325-9862.

Peripheral Vascular Disorders
For: Physicians. Symposium, March 15-16, 1985, St. Louis, Missouri. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, Missouri 63110. **Fee:** $150.00. **Reg. Limit:** 150. **Contact:** Loretta Giacoletto. **Phone:** (800)325-9862

APRIL

Allergy
Gastroesophageal Reflux
For: Allergists. Lecture, April 22, 1985, 8:00 PM, Holiday Inn Chicago City Centre. **Sponsor:** Illinois Society of Allergy & Clinical Immunology, 800 E. Northwest Highway, #101, Mount Prospect, Illinois 60056. **Fee:** $15.00 dinner. **Reg. Limit:** None. **Credit:** Category 1, 1 hour. **Contact:** Dianne K. Kubis. **Phone:** 312-255-1024.

General Medicine
Care of the Aging Patient
For: Physicians. Symposium, April 11-12, 1985, St. Louis, Missouri. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, Missouri 63110. **Fee:** $200.00. **Reg. Limit:** 150. **Credit:** AAFP prescribed, 13.5 hours; AMA Category 1, 13.5 hours; AOA, 13.5 hours. **Contact:** Loretta Giacoletto. **Phone:** (800)325-9862.

Eighth Annual Sports Medicine Symposium
For: Physicians, Nurses, Therapists. Symposium, Lectures, April 12-13, 1985, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, 465b WARF Bldg., 610 Walnut Street, Madison, Wisconsin 53705. **Fee:** TBD. **Reg. Limit:** None. **Credit:** Category 1, TBD hours; AAFP prescribed, TBD hours; AOA, TBD hours. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856. **Co-sponsor:** American College of Sports Medicine, University of Wisconsin Hospital.

Infectious Diseases
Infectious Disease Update—1985
For: Physicians, Nurses. Conference, April 18-19, 1985, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut Street, Madison, Wisconsin 53705. **Co-sponsor:** University of Wisconsin School of Medicine, Department of Medicine, Section of Infectious Diseases; University of Wisconsin Hospital. **Fee:** TBD. **Credit:** Category 1, TBD hours; AAFP prescribed, TBD hours; AOA, TBD hours. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Obstetrics-Gynecology
Electronic Fetal Monitoring Workshop
For: Ob-Gyn's. Workshop, April 13, 1985, 8:30-5:00, Chicago, Illinois. **Fee:** $135 (Fellows, Jr. Fellows of ACOG) $150 (others); $68 (Life Fellows, Jr. Fellow Residents). **Credit:** Category 1, 7 hours; ACOG Program for Continuing Professional Development, 7 hours. **Sponsor:** American College of Obstetrics and Gynecologists, 600 Maryland Avenue, S.W., Suite 300 East, Washington, DC 20024. **Contact:** Robin Murray. **Phone:** 202-638-5577 Ext. 343.

12th Annual Obstetrics and Gynecology Symposium
For: Physicians. Symposium, April 25-26, 1985, St. Louis, Missouri. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, Missouri 63110. **Fee:** $200.00. **Reg. Limit:** 150. **Credit:** AAFP prescribed, 12 hours; AMA category 1, 12 hours; AOA, 12 hours. **Contact:** Loretta Giacoletto. **Phone:** (800)325-9862.

Management of Complications of Gynecologic Surgery & Urology
For: Gynecologists, Urologists. Course, April 26-27, 1985, Chicago, Illinois. **Fee:** $225.00. **Credit:** AMA Category 1, 10 hours; ACOG, 10 hours. **Sponsor:** The University of Chicago, 5841 Maryland Avenue, Box 139, Chicago, Illinois 60637. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056.

Pathology
Clinical Toxicology in the Hospital and in the Medical Examiners Office
For: Pathologist. Lecture, April 8, 1985, 7:00 PM, Drake Hotel, Chicago, Illinois. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hours. **Sponsor:** Chicago Pathology Society, Loretto Hospital, 645 S. Central Avenue, Chicago, Illinois 60644-9987. **Co-sponsor:** Michael Reese Hospital and Medical Center. **Contact:** Marshall H. Short, MD. **Phone:** 312-626-4300 Ext. 5720.



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PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602.

BLOOMINGTON:
Internal Medicine—To join an active six member IM practice in mid-western university community. A sub-specialty in Rheumatology, Endocrinology, or Allergy is desirable, but not necessary. Contact: J. Buchanan, The Health Center, 702 N. East St., Bloomington 61701 (309-827-5051). (2)

FRANKFORT:
Multi-specialty group thirty miles southwest of Chicago seeks board elegible obstetrician-gynecologist to join expanding practice. Incentive plan, profit-sharing, relatively new building. Excellent practice opportunity with above average grade and high schools. Contact Howard Osmus, Administrator, Hedges Clinic, Frankfort, Il. 60423. (815-469-2123) (2)

KANE COUNTY:
Experienced occupational health physician needed to direct medical program in manufacturing plant in Southwest Suburbs. Call regional medical director (312)981-2195. (4)

ROCK ISLAND:
Internist group looking for a fourth physician to join growing area of Illinois Quad Cities. General internist and/or internist with sub-specialty willing to practice some general internal medicine. Offering financial guarantees and free rent for first year. Contact: Greg Romans, 2701 17th Street, Rock Island, IL 61201. (3)

SAYBROOK
Family practitioner—Excellent opportunity in east central Illinois; large modern office available; rural setting near modern well equipped community hospital; community is within twenty minutes of major universities, tertiary care centers; metropolitan area with major shopping, recreational and cultural activities available; financial incentives possible. Contact William Stack (309) 475-3521. (3)

VANDALIA
Specialists wanted. Family practice, internal medicine, pediatrics, general surgery, ENT, orthopedic surgery. One year guarantee with free office space. Needed for 92 bed acute, 134 bed LTC hospital in southern Illinois. Market covers 25,000+ people. Single office or clinic setting possible. Contact: Darrell Pile, Adm., Fayette Co. Hospital, Taylor Street., Vandalia, 62471 (618) 283-1231. (3)

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PHYSICIAN OPPORTUNITIES—Current openings for physicians of all specialties in the Illinois area and nationwide. Opportunities in solo, hospital and clinic based positions. For further information please contact Physician Recruiters Inc. at (312) 433-7180. All inquiries will be handled on a confidential basis.

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OB/GYN. Group Health Cooperative has 1984 opening for Board certified/eligible obstetrician and gynecologist. GHC is an established, rapidly expanding HMO. Staff enjoy a stable salary plus excellent benefit program including 5-6 weeks of time off plus $3,000 CME funding. Madison is a city of 200,000 population; University of Wisconsin; and 4 lakes. Contact: John Mueller, Group Health Cooperative, 1 South Park St., Madison, WI 53715; phone 608-251-4156.

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OBSTETRICIAN/GYNECOLOGIST—Board certified or eligible, to join multi-specialty group, midwestern community near Chicago. Excellent benefits, good salary first year, partner second year. Send CV to Frank H. Descourouez, M.D. or Nancy McMurray, Clinic Manager, Freeport Medical Clinic, Ltd., 750 South Kiwanis Dr., Freeport, Il. 61032.

INTERNIST—Board certified or eligible, to join multi-specialty group, midwestern community near Chicago. Excellent benefits, good salary first year, partner second year. Send CV to Frank H. Descourouez, M.D. or Nancy McMurray, Clinic Manager, Freeport Medical Clinic, Ltd., 750 South Kiwanis Dr., Freeport, Il. 61032.

EXCELLENT OPPORTUNITY for family physician to join growing northside medical group. Equity position in medical corporation available. No OB or Surgery. Membership on university affiliated hospital staff assured. Compensation $60,000 including benefits. Reply with resume to Box #1143, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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FAMILY PRACTICE OPPORTUNITIES exist with several expanding Marshfield Clinic, hospital-affiliated satellites in north central Wisconsin. The board certified/board eligible candidate will share the philosophy of oriented care with a preventive focus, enjoy the support of over 200 physician and surgeon specialists, and live at the doorstep of year round recreational activities. Marshfield Clinic offers an excellent salary and benefit program including a liberal vacation and education leave. Please send curriculum vitae to: John P. Folz, Assistant Director, 1000 North Oak, Marshfield, Wisconsin 54449.

INTERNIST—BC/BE with or without subspecialty to join well established group in midwest community near Chicago. Excellent salary and benefits first year with partnership second. Send CV to Frank H. Descourouez, M.D., President, Freeport Medical Clinic, Ltd., 750 S. Kiwanis Drive, Freeport, Illinois 61032. Telephone 815/235-6131.

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GOOD GENERAL OR INTERNAL MEDICINE practice wanted in Chicago or southwest suburb. Reply to Box #1133, c/o the *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

INTERNIST, certified, seeking full time or part time position in Chicago or suburbs. Certified in gastroenterology and life insurance medicine. Master of business administration degree (hospital administration). Will consider internal or occupational medicine, student or employee health, medical underwriting or administration. Write to Box #1145, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

BOARD CERTIFIED family practitioner, 2 yrs experience, seeks association with single or multispecialty group, or well established practice to buy in Chicago northwest suburb. Write to Box #1142, c/o the *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602, or call (312) 763-0723.

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POSITION WANTED 1983 graduate and board certified physician assistant seeking full-time employment in Chicago area. Experience in CV surgery, cardiology and family practice. Will consider all areas of medicine. Send inquiries to Marianne Engels, 1982 Kenilworth Circle H., Hoffman Estates, Illinois 60195, or call 312-310-1995.

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PHYSICIAN's FIRST-FLOOR office suite, in use 40 years. Adjacent spacious residence can be available if desired. Contact Elgin Realty Agency, 241 So. State, Elgin, Ill. 60120. (312) 741-8500.

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ATTRACTIVE MASONRY BUILDING in excellent condition housing 14 medical suites and pharmacy. Available due to the owner's retirement. Annual income $48,000. Full price $200,000. IREC, Inc. Melaine Everett, 312/679-5400.

SPLENDIDLY LOCATED 196 acres farm adjacent one mile to the championship 18 hole golf course and suitable for a multiple unit and commercial development. Priced only $600,000. Attractive financing. IREC, Inc. Melanie Everett, 312/679-5400.

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FOR LEASE: PRIME OFFICE space—1500 sq feet on the 32nd floor of the Pittsfield Building, 55 E. Washington, Chicago. Has been the main office of two busy internists; 4 exam rooms, laboratory, private restroom, business office, consultation room, storage space; very large waiting area. Please call for sublet (312) 726-5616.

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BRUMBY AND MELSON ROCKERS® available by mail for home and office. Also other fine rocking chairs in wood and leather. Write for our free catalog. The Rocker Shop™ of Marietta, GA, P.O. Box 12, Dept. ILS, Marietta, GA 30061, (404) 427-2618.

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SORBITRATE®
(ISOSORBIDE DINITRATE)

Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks. Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites. Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established. If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE. The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur. Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory. The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined. However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals. On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers. In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal. The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly.

Information for Patients: Headache may occur during initial therapy with SORBITRATE. Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates

Isosorbide dinitrate acts directly on vascular smooth muscle; therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug. A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose. There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman.

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related. In clinical trials at various doses, the following have been observed

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent. Cutaneous vasodilation with flushing may occur. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur. Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg; for oral (swallowed) tablets, 5 to 20 mg, and for controlled-release forms, 40 mg

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose. In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure.

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours. Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended. The extent to which development of tolerance should modify the dosage program has not been defined. *The oral controlled-release forms of isosorbide dinitrate should not be chewed*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg), Chewable Tablets (5, 10 mg), Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg)

STUART PHARMACEUTICALS
Division of ICI Americas Inc.
Wilmington, DE 19897

STR-2282

Time For Us To Be Heard



When we embarked upon our effort for malpractice reform last spring, the reaction outside the medical community was lukewarm at best. The media viewed it as a feud between physicians and attorneys. Public awareness and support were all but absent.

We've come a long way since then. The malpractice problem is now correctly perceived as affecting all the citizens of our state—as everybody's problem.

The Governor has created a multidisciplinary blue-ribbon task force to investigate the malpractice problem and offer recommendations to the General Assembly. News and editorial reports have exhibited a much better understanding of the breadth and depth of the malpractice dilemma. Businessmen, community leaders and others outside the health professions have now begun to realize that malpractice is a problem not only for the medical society but for society in general.

Even members of the legal profession, once adamantly opposed to any change in existing law, now concede that there probably are too many unfounded suits, although they still believe that nothing should be done to limit the size of damage awards.

The legislature is now in session. We must take advantage of the improving environment. County societies and hospitals which have formed action teams must start them working. Those who have not formed teams must do their best to organize them now.

Every representative and senator must be contacted. That contact must come from physicians, hospital administrators and trustees, ancillary health care personnel, local civic leaders, Auxilians and our patients. Contact must come from the legislators' own districts because they respond to their constituents. Those constituents hold the answer to malpractice reform.

Each of us can play an important role in the professional liability initiative. Make sure your hospital staff or county medical society has an action team in place and working. Write or call or meet with your legislators today. Encourage your colleagues and patients to do the same. The more contact the greater the impact. Individually and collectively, we can be successful. Let us let our voices be heard! ◂

Robert C. Hamilton, M.D.
President

P.S. If you're unsure of who your legislator is or the proper approach to use when discussing the issue, call the Governmental Affairs Division of ISMS today at (312) 782-1654 or (800) 782-ISMS.



Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL® LA**
(PROPRANOLOL HCl) LONG ACTING CAPSULES



Ayerst®

The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories

JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

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New York, N.Y. 10017



MALPRACTICE IS NO GAME.

But that's how some malpractice insurers look at it. They move numbers around to match premiums with payouts and profits . . . with little regard for what it means to you.

The Exchange is different. We don't like the high cost of malpractice. We don't profit from a legal system out of control.

The Exchange *cares* about its policyholders. That's why we're making an all-out effort to address the real cause of the malpractice problem—frivolous suits and inappropriate awards.

The Exchange is the only insurance carrier that's trying to do something about the problem. We're working hand-in-hand with the Illinois State Medical Society in a major initiative to improve the legal system. Our goals are to see that truly injured patients receive just compensation, juries are better able to make fair and judicious decisions, and the courts are not cluttered with frivolous and costly suits.

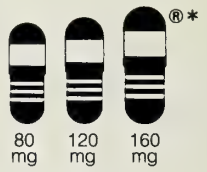
Ask any other carrier what they're giving you for your premium dollars. Then call the Exchange and ask about the Exchange's malpractice initiative and its protection program. Then compare. You'll see that no other carrier measures up to the Exchange.

Illinois State Medical Inter-Insurance Exchange

Twenty North Michigan Avenue, Suite 700 / Chicago, Illinois 60602
(312) 782-2749 800-782-ISMS (toll-free)

JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

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MALPRACTICE IS NO GAME.

But that's how some malpractice insurers look at it. They move numbers around to match premiums with payouts and profits . . . with little regard for what it means to you.

The Exchange is different. We don't like the high cost of malpractice. We don't profit from a legal system out of control.

The Exchange *cares* about its policyholders. That's why we're making an all-out effort to address the real cause of the malpractice problem—frivolous suits and inappropriate awards.

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Twenty North Michigan Avenue, Suite 700 / Chicago, Illinois 60602
(312) 782-2749 800-782-ISMS (toll-free)

Obituaries

***Anthony, Paul K.,** Evergreen Park, died December 16, 1984 at the age of 75. Dr. Anthony was a 1936 graduate of the Loyola University Stritch School of Medicine, Maywood.

****Di Cosola, Ralph M.,** Ashville, North Carolina, died December 1, 1984 at the age of 82. Dr. Di Cosola was a 1927 graduate of the University of Illinois College of Medicine, Chicago.

***Farrell, William J.,** Evergreen Park, died December 7, 1984 at the age of 61. Dr. Farrell was a 1947 graduate of the St. Louis University School of Medicine.

Greene, Lois D., Highland Park, died November 8, 1984 at the age of 87. Dr. Greene was a graduate of the University of Chicago Medical School.

Hall, Clifton F., Springfield, died November 1, 1984 at the age of 81. Dr. Hall was a 1930 graduate of the University of Louisville School of Medicine.

***Hause, Wetland A.,** Decatur, died November 23, 1984 at the age of 72. Dr. Hause was a 1938 graduate of Jefferson Medical College of Thomas Jefferson University, Philadelphia.

***Ihnchak, Michael D.,** Downers Grove, died December 27, 1984 at the age of 62. Dr. Ihnchak was a 1945 graduate of the Loyola University Stritch School of Medicine, Maywood.

***King, Thomas J.,** Oak Forest, died December 28, 1984 at the age of 64. Dr. King was a 1945 graduate of the Loyola University Stritch School of Medicine, Maywood.

McDonald, James H., Scottsdale, Arizona, died November 6, 1984, at the age of 69. Dr. McDonald was a graduate of the University of Illinois College of Medicine.

****Norten, Fred R.,** Rockford, died December 25, 1984 at the age of 87. Dr. Norten was a 1922 graduate of Medizinische Fakultat der Universitat Koln, Nordrhein-Westfalen.

***Pevsner, Leo,** Palatine, died November 21, 1984 at the age of 75. Dr. Pevsner was a 1949 graduate of the University of Illinois College of Medicine, Chicago.

****Sinnock, Hildegarde,** Quincy, died January 6, 1985, at the age of 92. Dr. Sinnock was a 1918 graduate of the Johns Hopkins University School of Medicine, Baltimore.

***Skaggs, Frank P., Jr.,** Harrisburg, died October 15, 1984 at the age of 75. Dr. Skaggs was a 1949 graduate of the University of Health Sciences/Chicago Medical School.

***Stevenson, Walter, Jr.,** Quincy, died January 6, 1985 at the age of 73. Dr. Stevenson was a 1937 graduate of the Washington University School of Medicine, St. Louis.

****Whitsell, Fay M.,** Chicago, died December 10, 1984 at the age of 79. Dr. Whitsell was a 1929 graduate of Jefferson Medical College of Thomas Jefferson University, Philadelphia.

****Winograd, Alvin M.,** Chicago, died December 9, 1984 at the age of 83. Dr. Winograd was a 1927 graduate of Northwestern University Medical School.

***Zukauskas, Ona E.M.,** Hinsdale, died November 6, 1984 at the age of 46. Dr. Zukauskas was a 1962 graduate of the University of Illinois College of Medicine, Chicago.

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*

BALANCED CALCIUM CHANNEL BLOCKADE!



Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page.

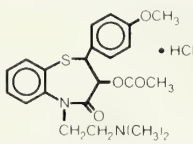
2/84

PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered.

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy** — CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/8

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Action Team Update

More action teams were formed as activity and interest in the professional liability initiative increased last month. Action teams are groups of physicians and health care personnel working to reach legislators, the media, patients, attorneys, civic/business leaders and others with facts about the seriousness of the professional liability problem. They seek support for proposals by the Illinois State Medical Society and the Illinois State Medical Inter-Insurance Exchange to address this problem.

County Medical Society Activity

Physicians in many counties are coordinating their action team activity through county medical societies. In Winnebago, Rock Island, DuPage, McLean, and St. Clair counties, county society leaders and staff are working hard to generate interest in the professional liability problem. Morgan M. Meyer, M.D., ISMS president-elect, has given the slide presentation for the public in a variety of DuPage County civic and business clubs. Dr. Meyer has met with much support, especially from such other professionals as accountants and architects.

In Winnebago County, the county medical society has formed a coordinating group of physicians to monitor and generate activity in local hospitals. Also in Winnebago County, local physicians are making a concerted effort to generate press activity. The county society is working with both print and the electronic media.

In St. Clair County, the physicians are also making an all out effort. Physicians of that county have made appearances before public groups, showing the public slide presentation and talking about the issue.

Sadiq Mohyuddin, M.D., president of the Madison County Medical Society, has shown the slide presentation and has contacted the local newspaper. An article resulting from this contact detailed the seriousness of the problem and the Illinois State Medical Society proposals.

In Lake County, Lake County Medical Society staff wrote a letter to the editor of one of the largest news-

(Continued on page 94)



Dr. Warren D. Tuttle, Harrisburg, (L) discusses the ISMS professional liability initiative with members of the Saline-Pope-Hardin County Medical Society at their January meeting. Dr. Tuttle is immediate past chairman of the ISMS Board of Trustees and currently serves as chairman of the Illinois State Medical Insurance Services Board of Directors.

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Medical Director: Sanford I. Finkel, M.D.
Hospital Administrator: Edward Goldberg

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Please see summary of product information on following page.

LIMBITROL® Ⓥ Tranquilizer-Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).
***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated, sedative effects may be additive Discontinue several days before surgery Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke
Psychiatric. Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns
Anticholinergic. Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus
Hematologic Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion
Other. Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling
Overdosage: Immediately hospitalize patient suspected of having taken an overdose Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning See complete product information for manifestation and treatment
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly
Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses
How Supplied: *Double strength (DS) Tablets,* white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets,* blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100, Prescription Paks of 50

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Action Teams

(Continued from page 89)

papers in that area. Its publication received much attention.

Legislative Activity

Many hospitals are inviting legislators to hospital medical staff meetings. Action teams are being urged to ask that hospital public relations personnel generate a press release following the legislator's appearance. This press release should be from the hospital and should report that the legislator attended the medical staff meeting to meet with the physicians about the seriousness of the professional liability problem and the ISMS proposals that address that problem. The purpose of the press release is twofold:

—It gives the legislator press in his own legislative district.

—It may generate story coverage of the issue and the ISMS proposals.

These contacts are productive. For example, one legislator suggested to a medical staff that they contact other legislators and urge them to be co-sponsors of the ISMS proposals.

In their invitation to legislators, action teams should be very clear as to the purpose of the meeting. Legislators appreciate knowing why they are being invited and what issue or issues will be addressed. If there is a letter of invitation to the legislator, (and we strongly suggest that a letter of invitation be sent, and come from a local physician on the medical staff) perhaps the ISMS issue document, "Malpractice Nobody Wins Everybody Pays: the Medical Malpractice Crisis in Illinois," might be enclosed.

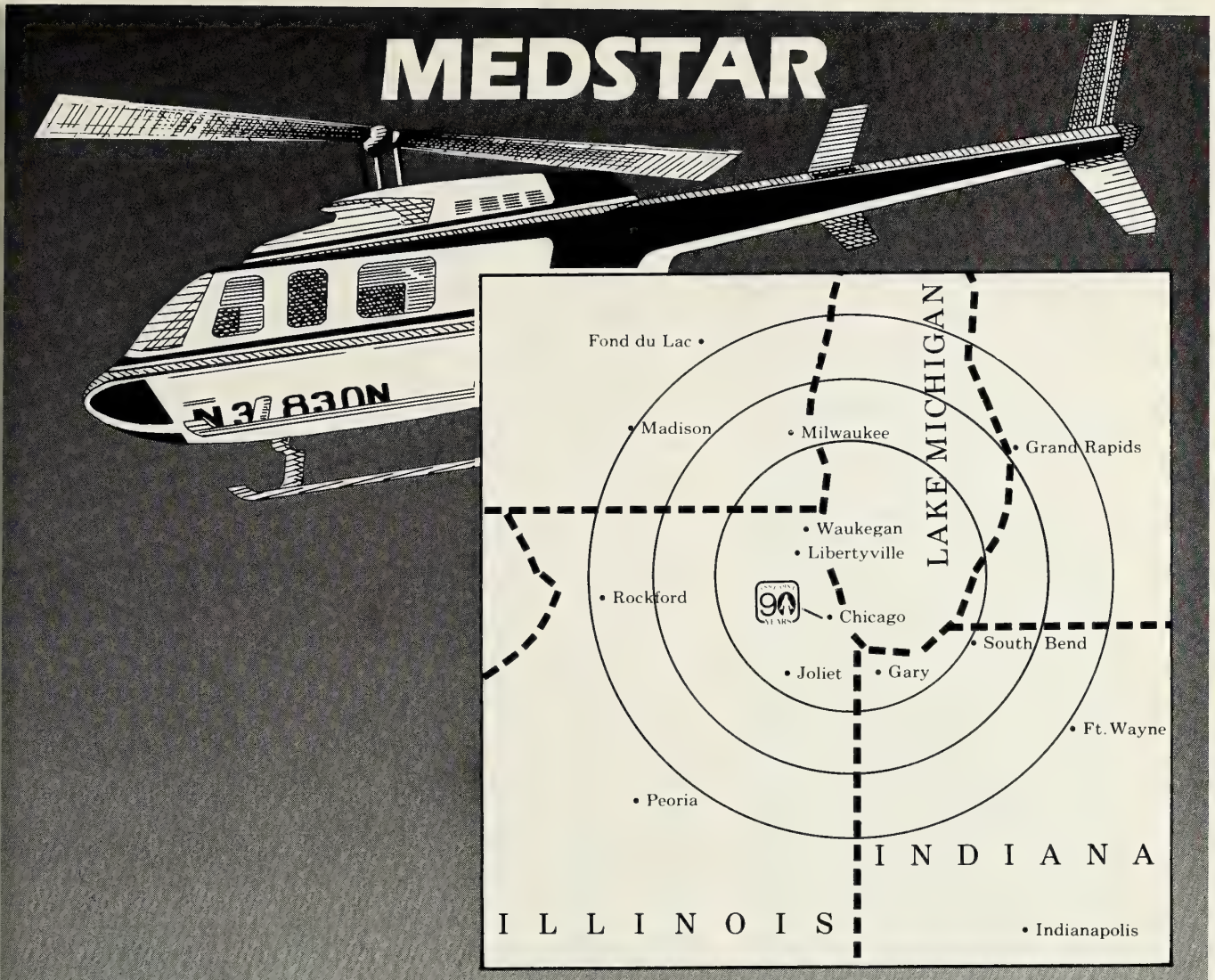
Media Activity

Action teams will soon receive a media kit for the professional liability initiative. Included in this kit will be instructions on how to contact the media and details on various media coverage possibilities, including editorial board endorsements, feature stories, general reporting, and letters to the editor/personal opinion coverage. Material will designate which local media the action team is responsible for. ISMS will work with appropriate action teams for the "core" blanket media (Chicago daily papers, the Chicago electronic media, and other statewide press).

Patient Brochures

Every ISMS member has received the issue document, patient brochure, patient questions and answers, an order card to order more patient brochures and a display for the office waiting room. Order card displays have been pouring in to ISMS headquarters. Physicians wishing to order patient brochures and the display can do so by addressing their request to the fulfillment officer, Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602 or calling the Society's toll free number 800-782-ISMS (in area code 312, dial 782-1654). ◀

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The Aging of Man and Medicine

By David J. Palmer, M.D. and Robert S. Danziger, M.D./Boston and Chicago

Americans are growing older. The question is: how can medicine best prepare itself?

Death rates among all ages, sexes, and races have been declining dramatically since 1950, resulting in a staggering increase and striking change in health care needs. Persons over 65 years of age, for example, utilize physician services more than those under 65, and are 2.5 times more likely to be hospitalized than younger people. The 1981 White House Conference on Aging estimated that by the year 2000 two-fifths of the total U.S. health care expenditures will be utilized by those over 65. This age group, according to the National Center for Health Statistics, will double by the turn of the century, constituting 12% of the population. Accordingly, nursing home demand will increase to a projected 2 million residents. Clearly, the impending health care scenario will impact on many levels of medical practice and federal, state, and local government policies.

Planning for changes in health care needs is being accomplished on multiple levels. Nationally, several task forces on aging have been organized, including the abovementioned White House Conference on Aging. The National Institute on Aging within the National Institute of Health was introduced in 1979 to coordinate research efforts related to aging and provide training fellowships in geriatric research. Encouraged by AMA policy on geriatric medicine,[1] specialty societies have also contributed nationally to the welfare of the aged. The American Academy of Ophthalmology, for example, recently sponsored a successful National Eye Care Project (NECP) pilot study in three states. Ophthalmologists voluntarily have provided free medical and surgical eye care to the uninsured needy over 65 years of age. Plans are evolving to include all 50 states in the project.

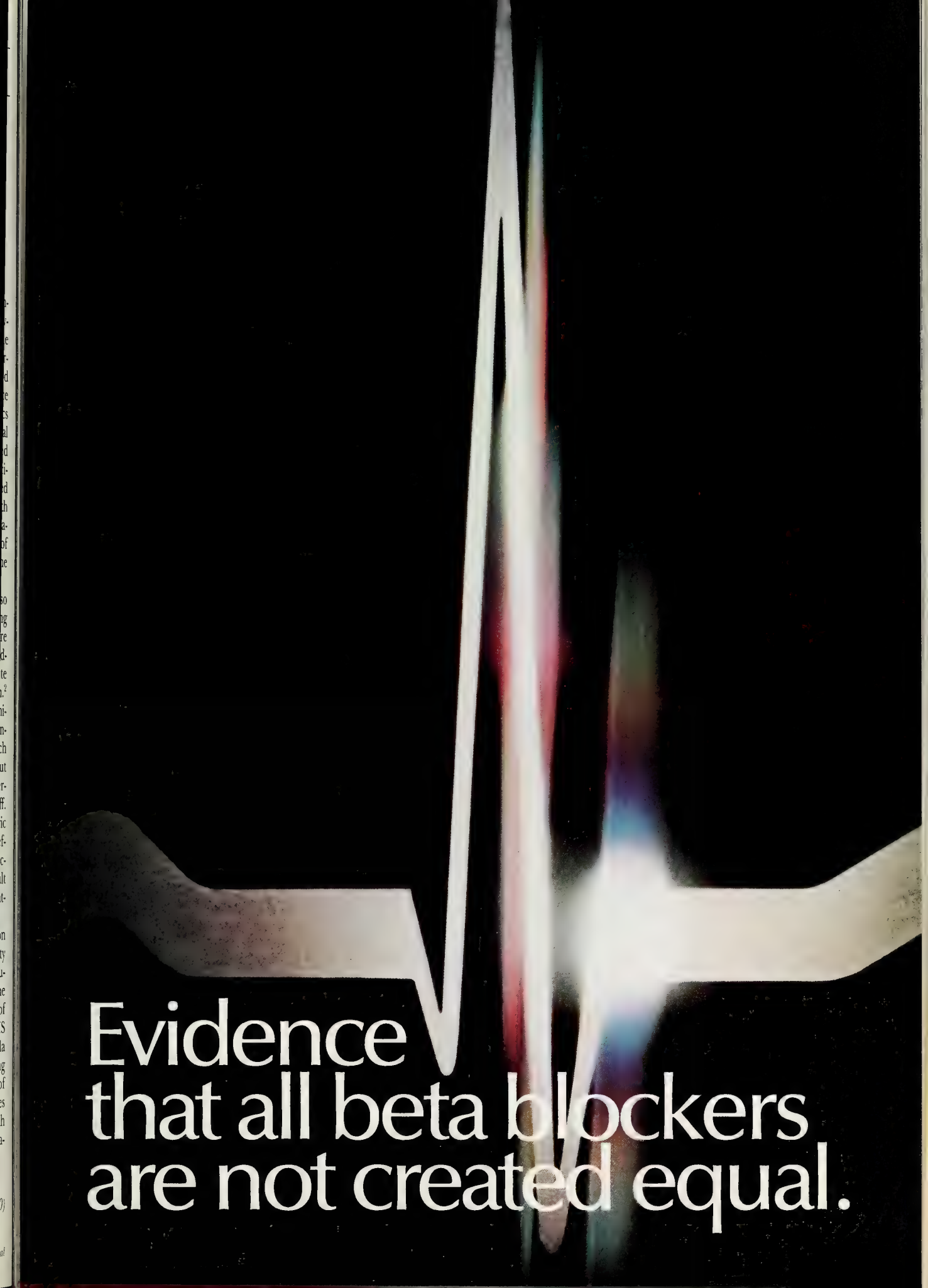
In Illinois, a statewide Department of Aging and a local Department of Aging and Disability in Chicago are studying ways in which the state and City of Chicago can best meet the health needs and social service requirements of the elderly. Through the efforts of Dr. Morton Creditor, chief of geriatric medicine at the University of Illinois at Chicago College of Medicine, and other colleagues, a Chicago Geriatric Society has been founded under the auspices of the Chicago Medical Society. Specifically, methods of case management, access to psychological counseling, delivery of home meals, assistance with housekeeping, transportation needs, and home health care possibilities are some of the problems that have been addressed by this committee. It is noteworthy that other state and local medical societies, such as the Massachusetts Medical Society, likewise have specific committees to study pertinent geriatric issues.

Several Illinois medical schools have incorporated geriatric and chronic-care related curricula in medical student and resident education. The University of Illinois Medical School in Chicago has formed a geriatrics subcommittee task force to outline geriatric medicine learning objectives that should be covered in medical school training. The committee has proposed a four-year curriculum to be integrated into the existing basic science courses and clinical training. Topics covered include the biological aspects of aging, anticipated changes in the age structure of society, problems unique to the aged (including aspects of mental health and support needs), communication with the elderly, and the role of the older person in society, to name a few.

The University of Illinois is also establishing a "teaching" nursing home which will be a chronic care facility staffed by teaching attendings who will use it as a clinical site for training and clinical research.[2] Such a facility exists in Rush University's Johnson R. Bowman Center for Geriatric Medicine, which serves as a focus for learning about the care and treatment of the elderly for both students and housestaff. Whatever the approach to geriatric medical education, beneficial effects lasting into one's clinical practice of medicine appear to result from seminars in aging and geriatrics during early training.[3,4]

The Resident Physician Section of the Illinois State Medical Society (ISMS-RPS) introduced a resolution (Resolution 20) before the ISMS assembly in the Spring of 1983 stating "that the ISMS encourage medical school curricula committees and residency training programs to address the issues of utilization of community resources and the strategies for dealing with the long-term medical, rehabilita-

(Continued on page 120)


Evidence
that all beta blockers
are not created equal.

New studies uncover the potassium effects of beta-2 blockade



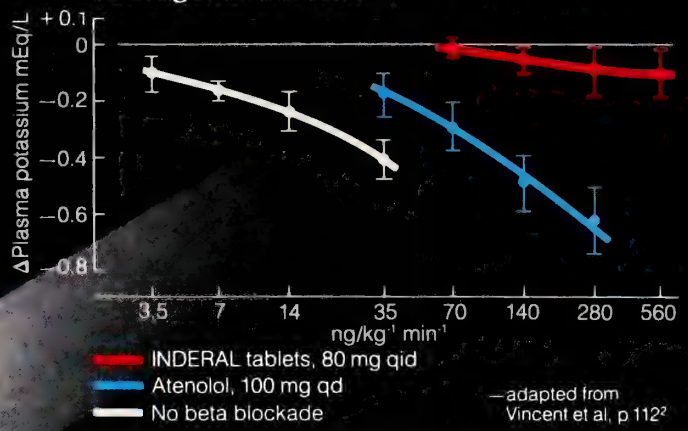
Clinical pharmacology data from the *New England Journal of Medicine:*

"...when normal young men are given infusions of epinephrine at levels such as those that circulate in patients with myocardial infarction, their serum potassium concentrations fall by about 0.8 mmol per liter. Hypokalemia is prevented by...beta-2 blockade."[1]

INDERAL (propranolol HCl) prevented beta-2 mediated hypokalemia

In a pharmacological study comparing INDERAL with atenolol, 10 hypertensive patients were infused with the nonselective beta agonist, isoproterenol, which also stimulates beta-2 mediated hypokalemia. At doses high enough to overcome beta-1 mediated heart rate reductions, the hypokalemia caused by isoproterenol was blunted by INDERAL, but not by atenolol.[2]

INDERAL compared with atenolol: change in plasma potassium after beta-agonist infusion[2]



—adapted from Vincent et al, p 112[2]

For beta-1/beta-2 blockade INDERAL® (PROPRANOLOL HCl) TABLETS

Please see last page for brief summary of prescribing information.

Epinephrine-induced hypokalemia can intensify diuretic-induced hypokalemia



From the *Lancet:*

"Although both diuretics and adrenaline are known to cause hypokalaemia, we believe that this is the first demonstration that these two factors can act in an additive manner. Routine monitoring of serum potassium in patients on thiazide diuretics may underestimate the risks of hypokalaemia."[3]

Epinephrine drives potassium into cells—an effect that has been shown to be under beta-2 receptor control[4]; thiazides promote excretion of potassium. When these actions occur together, hypokalemia can intensify significantly.[3]

Epinephrine-induced hypokalemia can cause ECG abnormalities typical of other forms of hypokalemia

In a study of the effects of epinephrine-induced hypokalemia on the electrocardiogram, it was shown that levels of plasma epinephrine similar to those observed during myocardial infarction can produce changes in ventricular repolarization, which are reflected in T-wave flattening and QT prolongation in normal subjects.[5]

In clinical pharmacology studies of hypertensive and normal patients, epinephrine-induced hypokalemia was prevented by beta-2 blockade.[2,4]

For beta-1/beta-2 blockade

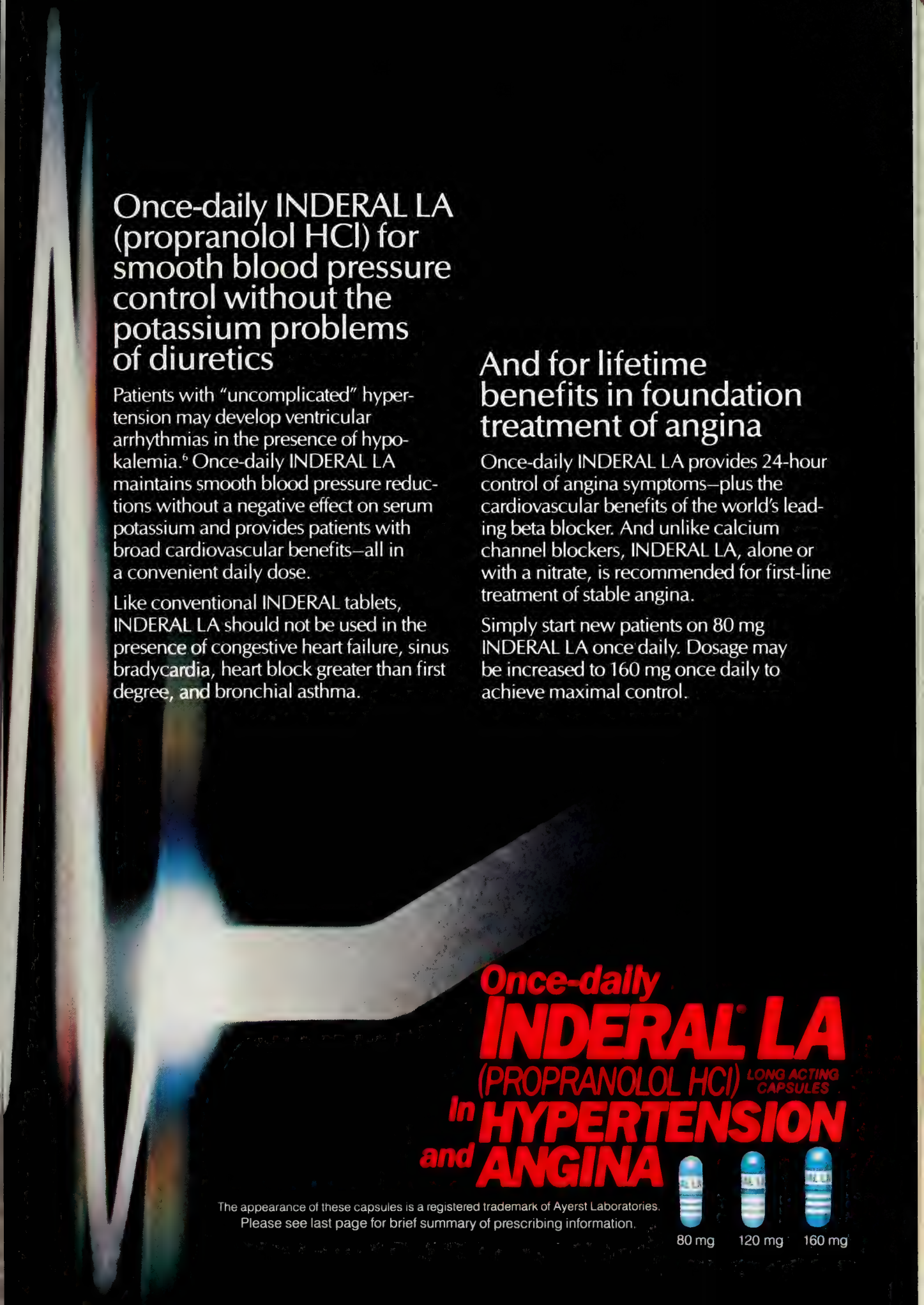
INDERAL®

(PROPRANOLOL HCl) TABLETS

Please see last page for brief summary of prescribing information.

Right from the start in hypertension...





Once-daily INDERAL LA (propranolol HCl) for smooth blood pressure control without the potassium problems of diuretics

Patients with "uncomplicated" hypertension may develop ventricular arrhythmias in the presence of hypokalemia.[6] Once-daily INDERAL LA maintains smooth blood pressure reductions without a negative effect on serum potassium and provides patients with broad cardiovascular benefits—all in a convenient daily dose.

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

And for lifetime benefits in foundation treatment of angina

Once-daily INDERAL LA provides 24-hour control of angina symptoms—plus the cardiovascular benefits of the world's leading beta blocker. And unlike calcium channel blockers, INDERAL LA, alone or with a nitrate, is recommended for first-line treatment of stable angina.

Simply start new patients on 80 mg INDERAL LA once daily. Dosage may be increased to 160 mg once daily to achieve maximal control.

Once-daily
INDERAL® LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES
In HYPERTENSION and ANGINA

The appearance of these capsules is a registered trademark of Ayerst Laboratories.
Please see last page for brief summary of prescribing information.

INDERAL®
(PROPRANOLOL HCl) TABLETS



10 mg 20 mg 40 mg 60 mg 80 mg 90 mg

The appearance of these tablets is a registered trademark of Ayerst Laboratories.

Once-daily INDERAL® LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES



The appearance of these capsules is a registered trademark of Ayerst Laboratories.

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULARS.)*
INDERAL® (propranolol hydrochloride) **Tablets and Injectable**
INDERAL® LA (propranolol hydrochloride) **Long Acting Capsules**

INDICATIONS AND USAGE—INDERAL Tablets

Hypertension: INDERAL (propranolol hydrochloride) is indicated in the management of hypertension. It may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL is indicated for the long-term management of patients with angina pectoris.

Cardiac Arrhythmias:

1.) Supraventricular arrhythmias

a) Paroxysmal atrial tachycardias, particularly those arrhythmias induced by catecholamines or digitalis or associated with the Wolff-Parkinson-White syndrome. (See W-P-W under WARNINGS.) b) Persistent sinus tachycardia which is noncompensatory and impairs the well-being of the patient. c) Tachycardias and arrhythmias due to thyrotoxicosis when causing distress or increased hazard and when immediate effect is necessary as adjunctive, short term (2-4 weeks) therapy. May be used with, but not in place of, specific therapy. (See Thyrotoxicosis under WARNINGS.) d) Persistent atrial extrasystoles which impair the well-being of the patient and do not respond to conventional measures. e) Atrial flutter and fibrillation when ventricular rate cannot be controlled by digitalis alone, or when digitalis is contraindicated.

2.) Ventricular tachycardias

Ventricular arrhythmias do not respond to propranolol as predictably as do the supraventricular arrhythmias. a)Ventricular tachycardias. With the exception of those induced by catecholamines or digitalis, INDERAL is not the drug of first choice. In critical situations when cardioversion technics or other drugs are not indicated or are not effective, INDERAL may be considered. If, after consideration of the risks involved, INDERAL is used, it should be given intravenously in low dosage and very slowly. (See DOSAGE AND ADMINISTRATION.) *Care in the administration of* INDERAL *with constant electrocardiographic monitoring is essential as the failing heart requires some sympathetic drive for maintenance of myocardial tone.* b) Persistent premature ventricular extrasystoles which do not respond to conventional measures and impair the well-being of the patient.

3.) Tachyarrhythmias of digitalis intoxication

If digitalis-induced tachyarrhythmias persist following discontinuance of digitalis and correction of electrolyte abnormalities, they are usually reversible with *oral* INDERAL. Severe bradycardia may occur. (See OVERDOSAGE.) Intravenous propranolol hydrochloride is reserved for life-threatening arrhythmias. Temporary maintenance with oral therapy may be indicated. (See DOSAGE AND ADMINISTRATION in the package circulars.)

4.) Resistant tachyarrhythmias due to excessive catecholamine action during anesthesia. Tachyarrhythmias due to excessive catecholamine action during anesthesia may sometimes arise because of release of endogenous catecholamines or administration of catecholamines. When usual measures fail in such arrhythmias, INDERAL may be given intravenously to abolish them. All general inhalation anesthetics produce some degree of myocardial depression. Therefore, when INDERAL (propranolol hydrochloride) is used to treat arrhythmias during anesthesia, it should be used with extreme caution and constant ECG and central venous pressure monitoring. (See WARNINGS.)

Myocardial Infarction: INDERAL is indicated to reduce cardiovascular mortality in patients who have survived the acute phase of myocardial infarction and are clinically stable.

Migraine: INDERAL is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta receptor stimulation. Clinical improvement may be temporary.

Pheochromocytoma: After primary treatment with an alpha-adrenergic blocking agent has been instituted, INDERAL may be useful as *adjunctive* therapy if the control of tachycardia becomes necessary before or during surgery.

It is hazardous to use INDERAL unless alpha-adrenergic blocking drugs are already in use, since this would predispose to serious blood pressure elevation. Blocking only the peripheral dilator (beta) action of epinephrine leaves its constrictor (alpha) action unopposed.

In the event of hemorrhage or shock, there is a disadvantage in having both beta and alpha blockade since the combination prevents the increase in heart rate and peripheral vasoconstriction needed to maintain blood pressure.

With inoperable or metastatic pheochromocytoma, INDERAL may be useful as an adjunct to the management of symptoms due to excessive beta receptor stimulation.

INDICATIONS AND USAGE—INDERAL LA Long Acting Capsules

Hypertension: INDERAL LA (propranolol hydrochloride) is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL and INDERAL LA are contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL (propranolol hydrochloride) therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL, like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

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SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies

From the Department of Alcoholism and Substance Abuse

The California Department of Alcohol and Drug Programs has learned of a possible association between intravenous or intra-nasal cocaine use by pregnant women and a separation of the placenta from the wall of the uterus (abruptio placenta). There is now a study of such cases going on in San Francisco.

Physicians who may have documentation of such cases are asked to contact Nancy Presson, Division of Drug Programs, San Francisco Department of Public Health, 170 Fell Street, Room 25, San Francisco, CA 94102 (415-558-2356).

(Source: Correspondence from the DASA office.)

From the Department of Public Health

Medical Device Problem Reporting Program

In order to increase participation in the Practitioner Reporting System (PRS), the Illinois Department of Public Health (IDPH) and the University of Illinois at Chicago (UIC) College of Pharmacy are developing a presentation on this program for Illinois hospitals. This is a national voluntary program for the reporting of problems that health practitioners have with various medical devices, agents, supplies and equipment.

Sixty randomly selected hospitals will be chosen by IDPH for participation in this project. The objective of the presentation to hospitals is to inform their staffs about the PRP and the proper methods for reporting medical device problems.

The Medical Device PRP collects information that concerns various design defects, device malfunctions, improper packaging, questionable sterility and inadequate labeling or instruction. The PRP is product-oriented and does not require patient information. Any follow-up, product recall or change in the manufacturing process becomes a joint effort between the industry and the FDA.

For more information about this project, contact Ronald Gottrich, Ph.D., at IDPH (217/782-7977) or Jesse Stewart at the UIC, (312/996-0878).

(Source: Correspondence from Jesse E. Stewart, Ph.D., UIC)

From the Department of Registration and Education

The following physicians were disciplined pursuant to orders signed by the Director of the Department based on recommendations of the Medical Disciplinary Board.

- *Robert W. Blumstein (lic. #36-39862)*
 On November 19, 1984, the license of Dr. Blumstein was suspended for 90 days and placed on a two year probation, subject to certain conditions.
- *Emanuel M. Herzon (lic. #36-25556 & 3-36-25556-1)*
 Effective November 10, 1984, Dr. Herzon surrendered his Controlled Substances license for an indefinite period.
- *Kevin G. Hoffert (lic. #36-51244 & 3-36-51244-1)*
 Effective November 10, 1984, the Medical and Controlled Substances licenses of Dr. Hoffert were placed under supervision for an indefinite period.
- *Lewis Jones*
 On October 31, 1984, the Director ordered that a Controlled Substances license not be issued to Lewis Jones.
- *David A. Katerndahl (lic. #36-62152 & 3-36-62152-1)*
 Effective November 10, 1984, the Medical license of Dr. Katerndahl was placed on a two-year probation and his Controlled Substances license was suspended for two years.
- *Erich Lehr (lic. #036-27686)*
 On December 5, 1984, the physician was reprimanded.
- *Payming Leu (lic. #036-43144)*
 On December 5, 1984, the department refused to restore Dr. Leu's Medical license.
- *Kishore Hansraj Shah (lic. #36-61631)*
 Effective December 15, 1984, the Medical license of Dr. Shah was suspended for an indefinite period.
- *Myriam Richardson Leonardo (a/k/a Myriam Wilson) (lic. #036-42976)*
 On November 10, 1984, the physician was reprimanded.
- *Milton Steinberg (lic. #036-16356 & 003-036-16356-1)*
 Effective December 10, 1984, the Controlled Substance license of Dr. Steinberg was suspended for an indefinite period and his Medical license was placed on probation for three years.
- *James H. Taylor (lic. #36-21374)*
 On October 31, 1984, the Director suspended Dr. Taylor's Medical license for an indefinite period.

(Source: Orders received by ISMS from the Department of Registration and Education).

EKG OF THE MONTH

CONTRIBUTING EDITOR JOHN F. MORAN, M.D., SECTION OF CARDIOLOGY, DEPARTMENT OF MEDICINE, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

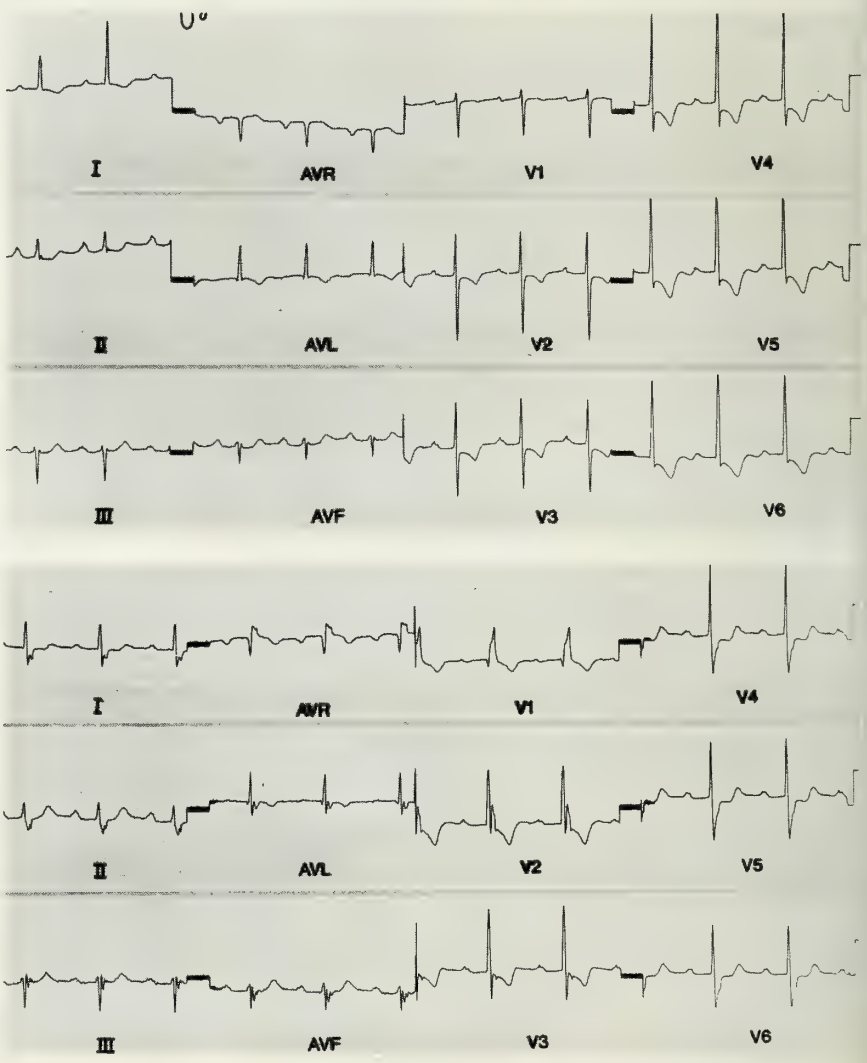
This patient is a 79 year old woman who complained of a new retrosternal chest pain without radiation. The pain was associated with nausea, dyspnea, and diaphoresis. Although two previous chest pains had been less severe and lasted minutes, this time the pain lasted one hour and was quite severe. She had been treated for hypertension for over 10 years and for an episode of congestive heart failure five years ago. Her medications included alphamethyldopa and digoxin. Her blood pressure was 118/68mmHg. Examination of the lungs showed bibasilar crepitant rales halfway up both lung fields. Atrial and ventricular gallop sounds were present on examination of the heart. A pulmonary artery catheter recorded normal right heart pressures. The first electrocardiogram was taken. She had no further pain for four days on heparin anticoagulation, propranolol, and nifedipine. Only alphamethyldopa was discontinued. On the fourth day, a prolonged retrosternal chest pain developed and the second electrocardiogram was obtained.

Questions:

1. **The electrocardiograms show:**
 a. Sinus rhythm with first degree atrioventricular (AV) block.
 b. Marked non-specific ST-T wave changes.
 c. Complete right bundle branch block.
 d. Complete left bundle branch block.
 e. An acute myocardial infarction.

2. **The following statement(s) is/are true.**
 a. This patient had an acute myocardial infarction.
 b. The presence of first degree AV block is a poor prognostic sign.
 c. The change in the second ECG worsens the prognosis.
 d. Congestive heart failure is not serious if it promptly responds to treatment.
 e. Vagal influences could account for some of the changes seen in these electrocardiograms.

(Continued on page 116)



Kodak presents...



New KODAK EKTACHEM DT60 Analyzer

A timely invest



The KODAK EKTACHEM DT60 Analyzer creates an extra service for your patients without extra investment in labor. And because it can pay for itself in three months, it's a timely investment in your future.

The chemistry tests you need

With the DT60 Analyzer you perform key chemistry tests in your own office instead of using an outside laboratory. Available tests include glucose, cholesterol, triglycerides, BUN, uric acid, sodium, and potassium, with total hemoglobin and bilirubin coming soon.

The time you need

Get test results in five minutes or less; perform up to 75 tests an hour. Save time waiting for results to assist in your diagnosis, and on follow-up phone calls.

The accuracy you need

The DT60 Analyzer uses proven technology and methodology from the KODAK EKTACHEM 400 and 700 Analyzers, which

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ment for your office.



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The Federal Food Stamps Program

By Alan J. Scharrer/Springfield

At the 1984 annual meeting of the AMA-MSS, an ISMS-MSS resolution was adopted which stated ". . . That the AMA communicate to the USDA its concern about the lack of nutritional guidelines for food stamp recipients and . . . that, due to the importance of nutrition in maintaining proper health for all Americans, the USDA reconstruct the Federal Food Stamps (FFS) Program to designate that purchases utilizing food coupons be for nutritionally beneficial foodstuffs only"[1] The MSS transmitted this resolution to the AMA House of Delegates as AMA Resolution 158 (A-84). The AMA House referred it to the AMA Council on Scientific Affairs for further study with the results of the study to be presented at the 1985 AMA annual meeting.

The final decision now rests with this committee. A more basic question is why such a resolution was needed in the first place. As the author of the resolution, it seems fitting that the task should be brought back to me.

Hunger in the world has always been an extremely unpleasant thought. That hunger exists here in the rich United States is unimaginable. Yet it does exist and this fact has been repeatedly brought to public attention, especially in the past two years. Sen. Edward Kennedy (D-Mass.) published a report at Thanksgiving two years ago that addressed this problem. He felt that the number of people who go to bed hungry was shocking. He offered measures to correct this problem but nothing substantive has arisen to date.

More recently, Archbishop Rembert Weakland of Milwaukee, speaking on behalf of the American Council of Catholic Bishops, stated that the existence of poverty in the United States was inexcusable and that the feeding of the hungry must be made a national priority. One need only look at the length of the bread lines to appreciate the full extent of his words. How to feed the hungry remains an enormous task. A valiant attempt is made through the utilization of the United States Department of Agriculture's (USDA) nutrition programs, most notably the FFS program. However, this program falls far short in educating its recipients on proper nutrition.

Proper nutrition, obviously, is required to correct many of the health problems currently plaguing the poor. Although they are needed, education programs on nutrition for the recipients of food stamps are virtually non-existent. Yet, a good proportion of the budget allotment for the food stamp program goes to nutrition education. Where are these monies actually spent? Research? Seminars? How are they benefitting those who need to know the proper, most efficient, healthy way to feed a family utilizing their allotment of food coupons? The answer is simple—the nutritionally uneducated remain so! The only "education" one receives as a food stamp recipient is looking at worn, faded posters while one waits to be seen by a caseworker.

The resolution, which is currently under consideration by the AMA Council on Scientific Affairs, attempts to address this obvious inconsistency. By remodeling the FFS program along lines similar to another federal program (entitled Women, Infants and Children Supplemental Food Program), recipients would be required to use their coupons for foodstuffs already designated as nutritious. This would decrease purchases of such items as carbonated beverages, snack foods, candy and other "foods" which add so little to the diet of those already nutritionally deprived. To many, this may sound overly paternalistic, but paternalism is already inherent in a program which is designated to help those who cannot help themselves.

Another benefit that this resolution could potentially provide is an area in the federal budget that could be cut! By alleviating the need for the nutrition education programs, one will also alleviate the need for funding. Another alternative for these monies would be to provide more funds to the FFS program itself—to increase the number of eligible recipients. This would certainly be more in line with the USDA's objective of feeding the hungry.

The FFS program has great potential to do good for its recipients. Unfortunately, due to obvious inadequacies, it has yet to fully realize this potential. This resolution is the AMA-MSS attempt to address this. It now rests with the AMA Council on Scientific Affairs. It is hoped that they too will see the necessity for this change in the FFS Program and recommend that AMA pass their recommendations on to the United States Department of Agriculture. ◀

References

1. AMA-MSS Resolution 1 (A-84): "Nutritional Guidelines for the Federal Food Stamps Program."

Alan J. Scharrer, a third year medical student, is the ISMS-MSS representative to the ISMS Council on Education and Manpower.

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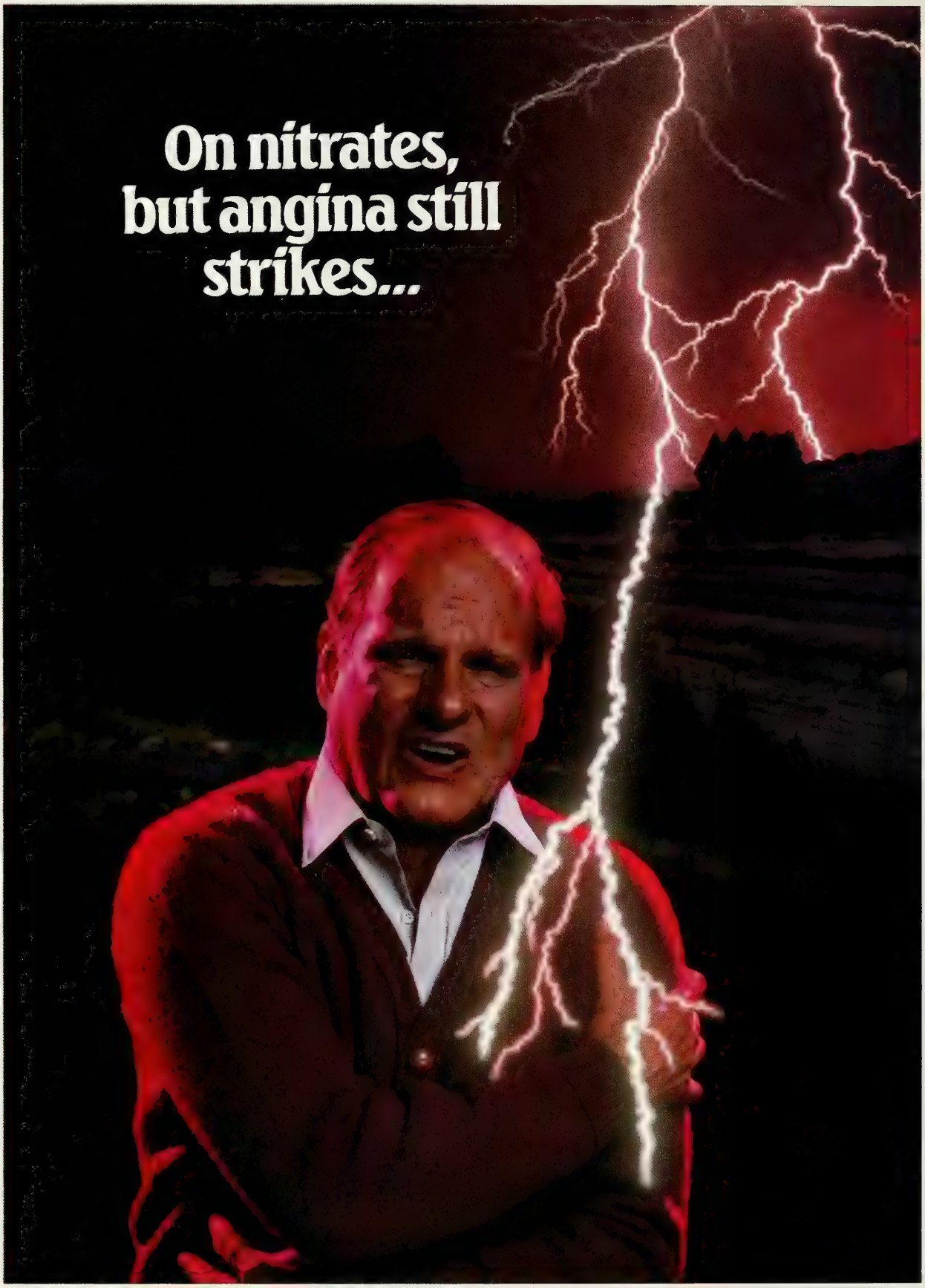
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Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction <30%) or moderate to severe symptoms of cardiac failure. Control milder heart failure with optimum digitalization and/or diuretics before ISOPTIN is used. ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild, and controlled by decrease in ISOPTIN dose). Occasional elevations of liver enzymes have been reported; patients receiving ISOPTIN should have liver enzymes monitored periodically. Patients with atrial flutter/fibrillation and an accessory AV pathway (e.g., W-P-W or L-G-L syndromes) may develop a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion. AV block may occur (3rd degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema, and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with ISOPTIN. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, patients should be monitored closely. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function or in patients who have also recently received methyldopa. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patient carefully monitored. ISOPTIN may have an additive hypotensive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR<50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%). The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: confusion, paresthesia, insomnia, somnolence, equilibrium disorders, blurred vision, syncope, muscle cramps, shakiness, claudication, hair loss, maculae, and spotty menstruation. Overall continuation rate of 94.5% in 1,166 patients. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in 80 mg and 120 mg sugar-coated tablets. July 1982 2068

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Extra security added to proven efficacy and safety

No longer do doctors have to deny patients the benefit of an effective oral analgesic for fear of its misuse by injection.

Winthrop-Breon Laboratories has met a nagging problem by reformulating TALWIN® 50 (pentazocine HCl tablets) with the addition of naloxone, equivalent to 0.5 mg base. The reformulated product is called TALWIN® Nx.

The original formulation had been subject to a form of misuse among street abusers known as "T's and Blues." TALWIN 50 and PBZ,* an antihistamine, would be ground up together, put into solution, and injected intravenously. The combination produced a heroin-like high. Because naloxone is a narcotic antagonist when injected intravenously, it acts to nullify any high a "T's and Blues" addict might expect from the pentazocine in a combination of TALWIN Nx and PBZ. When taken as directed orally, the naloxone component of TALWIN Nx is inactive. Thus, TALWIN Nx continues to be a safe, effective, oral analgesic for the relief of moderate to severe pain, now providing added security against misuse.

*Registered trademark of Ciba-Geigy Corp for tripelennamine.



The reformulation of Talwin 50 to Talwin Nx involved the addition of 0.5 mg naloxone to help prevent misuse by injection.

*In Illinois, TALWIN Nx is a Schedule II controlled substance and requires a triplicate prescription.

Winthrop-Breon

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Please see following page for Brief Summary.

Talwin® Nx (IV)

Each tablet contains pentazocine HCl, USP, equivalent to 50 mg base and naloxone HCl, USP, equivalent to 0.5 mg base

Analgesic for Oral Use Only

Contraindications: Hypersensitivity to either pentazocine or naloxone.

TALWIN® Nx is intended for oral use only. Severe, potentially lethal, reactions may result from misuse of TALWIN® Nx by injection either alone or in combination with other substances. (See **Drug Abuse and Dependence** section.)

Warnings: *Drug Dependence.* Can cause physical and psychological dependence. (See **Drug Abuse and Dependence**.) *Head Injury and Increased Intracranial Pressure.* As with other potent analgesics, respiratory depressant effects of the drug may elevate cerebrospinal fluid pressure due to CO_2 retention; these effects may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Can obscure the clinical course of patients with head injuries; in such patients, use with extreme caution and only if deemed essential. *Usage with Alcohol.* Due to potential for increased CNS depressant effects, alcohol should be used with caution. *Patients Receiving Narcotics.* Pentazocine is a mild narcotic antagonist. Withdrawal symptoms have occurred in patients previously given narcotics, including methadone. *Certain Respiratory Conditions.* Should be administered with caution in respiratory depression from any cause, severely limited respiratory reserve, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Precautions: *CNS Effect.* Use cautiously in patients prone to seizures; seizures have occurred though no cause and effect relationship has been established. Therapeutic doses have in rare instances, resulted in hallucinations (usually visual), disorientation, and confusion, which cleared spontaneously within a period of hours. Such patients should be very closely observed and vital signs checked; if the drug is reinstituted, it should be done with caution since the acute CNS manifestations may recur. *Impaired Renal or Hepatic Function.* Decreased metabolism of pentazocine in extensive liver disease may predispose to accentuation of side effects; it should be administered with caution in renal or hepatic impairment. In long-term use, precautions should be taken to avoid increases in dose by the patient. *Biliary Surgery.* Some evidence suggests that unlike other narcotics pentazocine causes little or no elevation in biliary tract pressures; the clinical significance of these findings is not yet known. *Information for Patients.* Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards. May cause physical and psychological dependence taken alone and may have additive CNS depressant properties in combination with alcohol or other CNS depressants. *Myocardial Infarction.* Use with caution in patients with myocardial infarction who have nausea or vomiting. *Drug Interactions. Usage with Alcohol:* See **Warnings**. *Carcinogenesis, Mutagenesis, Impairment of Fertility.* No long-term studies in animals to test for carcinogenesis have been performed. *Pregnancy Category C.* Should be given to pregnant women only if clearly needed. *Labor and Delivery.* Use with caution in women delivering premature infants. Effect on mother and fetus, duration of labor or delivery, need for forceps delivery or other intervention or resuscitation of newborn, or later growth, development, and functional maturation of the child is unknown. *Nursing Mothers.* Caution should be exercised when administered to a nursing woman. *Pediatric Use.* Safety and effectiveness in children below the age of 12 years have not been established.

Adverse Reactions: *Cardiovascular:* Hypotension, tachycardia, syncope. *Respiratory:* Rarely, respiratory depression. *CNS Acute CNS Manifestations:* In rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours, may recur if drug is reinstituted. *Other CNS Effects:* Dizziness, lightheadedness, sedation, euphoria, disturbed dreams, hallucinations, irritability, excitement, tinnitus, tremor. *Gastrointestinal.* Nausea, vomiting, constipation, diarrhea, anorexia, rarely abdominal distress. *Allergic:* Edema of the face; dermatitis, including pruritus; flushed skin, including plethora. *Ophthalmic:* Visual blurring and focusing difficulty. *Hematologic:* Depression of white blood cells (especially granulocytes), which is usually reversible, moderate transient eosinophilia. *Other:* Headache, chills, insomnia, weakness, urinary retention.

Drug Abuse and Dependence: *Controlled Substance.* TALWIN Nx is a Schedule IV controlled substance.

Dependence and withdrawal symptoms have been reported with orally administered pentazocine. Patients with a history of drug dependence should be under close supervision. Possible abstinence syndromes in newborns after prolonged use of pentazocine during pregnancy have been reported. In prescribing for chronic use, the physician should take precautions to avoid increases in dose by the patient. Tolerance to the analgesic effect is rarely reported; there is no long-term experience with oral use of TALWIN Nx.

The amount of naloxone present (0.5 mg per tablet) has no action when taken orally and will not interfere with the pharmacologic action of pentazocine; however, this amount of naloxone given by injection has profound antagonistic action to narcotic analgesics. TALWIN Nx has a lower potential for parenteral misuse than the previous oral pentazocine formulation, but is still subject to patient misuse and abuse by the oral route.

Severe, even lethal, consequences may result from misuse of tablets by injection either alone or in combination with other substances, such as pulmonary emboli, vascular occlusion, ulceration and abscesses, and withdrawal symptoms in narcotic dependent individuals.

Overdosage: *Treatment.* Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. For respiratory depression, parenteral naloxone is a specific and effective antagonist.

Please consult full product information before prescribing.

Winthrop-Breon

WIN 4-41415AR2

Winthrop-Breon Laboratories
Division of Sterling Drug Inc
New York, NY 10016

EKG

(Continued from page 106)

Answers: 1. A, B, C. 2. A, C.

The first ECG shows sinus rhythm at a rate of 75 beats/minute and first degree AV block with a PR interval of 0.26 seconds. There is marked ST segment depression and T wave inversion in leads V_3 thru V_6 but no real evidence of a transmural myocardial infarction. The ST-T wave changes are compatible with a non-transmural or subendocardial infarction but are not diagnostic. The clinical history of severe chest pain, the physical examination of congestive heart failure and peak elevation of creatine kinase to 411 units with positive MB isoenzymes confirmed the diagnosis of acute myocardial infarction. SGOT and LDH enzymes were also elevated. In patients admitted to coronary care units, first degree AV block is mostly due to block above the bundle of His. A poor prognosis is associated with block below the bundle of His. This is associated with bundle branch disease and anterior myocardial infarction. Vagal tone can cause PR prolongation early in the course of an infarction, especially inferior wall myocardial infarctions. In this patient, the PR interval was prolonged initially to 0.26 seconds and later, in the second ECG, the PR interval was longer at 0.32 seconds. In the second ECG, the QRS is prolonged with an RsR' pattern of complete right bundle branch block. Isolated first degree AV block with a normal QRS duration does not progress to higher grades of AV block in most cases. However, the presence of a bundle branch block of recent onset with first degree AV block increases the risk of high degree AV block. The bundle branch block increases the mortality risk two to three times in the setting of acute myocardial infarction. Hospital mortality in acute infarctions is often related to congestive heart failure. Even easily treated congestive heart failure has a poor prognosis.

This patient had sustained heart failure five years earlier. Now she had heart failure again with the acute subendocardial infarction. The accumulated myocardial damage was significant. Cardiogenic shock developed shortly after the appearance of the complete right bundle branch block and the patient expired. ◀

DOCTOR'S NEWS

Correction of Annual Meeting Dates

Last month's Doctor's News column included incorrect dates for the 1985 annual meeting of the House of Delegates.

The ISMS House of Delegates annual meeting will convene Friday through Sunday, April 26-28, at the Marriott O'Hare Hotel. The annual meeting dates shown last month (April 24-27) were in error. We apologize for this error and any inconvenience it may have caused.

The Illinois State Medical Inter-Insurance Exchange annual meeting is scheduled for April 24, also at the Marriott O'Hare.

A full convention program will be published in the March issue of *IMJ*.

As reported last month, resolutions for House of Delegates consideration must be *received* in the ISMS offices by March 22. Those received after that date will be considered late resolutions and will need approval by a special committee prior to acceptance.

Resolutions will be published in the March *IMJ* by author and subject. However, only those resolutions received in the ISMS offices by an earlier deadline, February 20, can be published.

Intrauterine Deaths Reported

As this issue went to press, the *Journal* received communication from St. Vincent Memorial Hospital in Taylorville reporting an unusually high incidence of intrauterine deaths in the first weeks of 1985. All occurred in the first 8-12 weeks of gestation and all mothers complained of recent flu or severe upper respiratory tract infection. An influenza-type illness was reportedly prevalent in the area during this period. Correspondence noted that the number of intrauterine deaths was grossly out of proportion to typical experience. Physicians experiencing similar incidents may direct reports to the Illinois Department of Public Health, division of family health, 535 W. Jefferson St., Springfield IL 62706; (217-782-2737).

Physicians in the News

Dr. **Maurice F. Rabb,** Chicago, has been appointed interim associate vice chancellor for urban health at the University of Illinois at Chicago (UIC). In his new position, Dr. Rabb assumes responsibility for the university's urban health program, which is designed to increase the number of blacks, Hispanics and native Americans in the health professions. Dr. Rabb will continue as professor of clinical ophthalmology at the university as well as director of UIC's comprehensive sickle cell center.

Dr. **Robert E. Field,** Blue Island, was recently elected president of the Civil Aviation Medical Association (CAMA) at the group's 19th annual meeting in Monterey, California. The CAMA is an association of aviation medical examiners whose chief objective is to define the basic mental and physical requirements of civil airmen. Dr. Field, a general and thoracic surgeon at St. Francis Hospital, Blue Island, served for years as a director and secretary-treasurer of CAMA.

Dr. **Nelson Sanchez,** Oak Park, has been named president of the medical staff at Saint Mary of Nazareth Hospital Center, Chicago. Dr. Sanchez is medical director of the hospital's mental health center. Other officers elected include Drs. **Joseph Danon,** Chicago, president-elect; **Adolpho Llano,** Chicago, secretary; **Thaddeus Zamirowski,** Chicago, treasurer; and **Franchot Wang,** Chicago, staff representative.

Dr. **Rafael Machado,** Northbrook, has been elected president of the medical/dental staff of Saint Francis Hospital, Evanston. Dr. Machado is chairman of anesthesiology at the hospital and an assistant professor of anesthesiology at the Loyola University Stritch School of Medicine. Dr. **Carlos H. Escamilla,** Wilmette, was elected president-elect, and Dr. **Alexander A. Constantaras,** Winnetka, was named secretary-treasurer. Members at large elected were Drs. **Arnold S. Berns,** Highland Park; **Carl T. Boraca,** Glenview; and **Jay J. Gold,** Wilmette.

Schedule High Blood Pressure Control Conference

A "National Conference on High Blood Pressure Control," has been scheduled for April 29-30 at the Palmer House Hotel, Chicago. Highlights of the conference will include a critique of the 1984 Joint National Committee Report on Detection, Evaluation, and Treatment of Hypertension; debates on the treatment of mild hypertension; and reviews of some of the results of effective blood pressure management in the U.S. during the past 12 years. Registration fee for the conference is $165. Registration information is available through conference headquarters: 2121 Wisconsin Ave., N.W., Washington, DC 20007, (202) 944-3176.

Public Image Campaign

Improving the public image of physicians will be the objective of a major American Medical Association education campaign to increase the nation's awareness that physicians are advocates for their patients. The long-range public relations campaign was approved by the AMA House of Delegates during its December meeting. The House also directed the AMA Board of Trustees to strengthen the association's efforts to inform the public about changes that are occurring in health care delivery and the impact these changes will have on quality and access.

Locker Room Toughies

Dear Editor:

In the immediate past I have really been covered up. The volume of material coming out of the Medical Society in regard to malpractice and the professional liability insurance has kept me burning the midnight oil. And on weekends, there was football—but more of that later.

It seems as though the all-consuming interest of the Medical Society is directed at solving, at least in part, the huge costs generated as a result of the liability-litigation crisis. There is no question but what you have developed the data, the system, the material, and that your leaders are dedicated and enthusiastic.

Mt. Hawley has a unit school district. This has allowed us to consolidate all of our educational efforts; and, with the enlarged student body in high school, we now have enough students to form a football team. In order to have a team, one must have at least 22 willing souls and that requires a larger student body. The community pressure is such that the notion of a football team swelled our civic pride, and the P.E. teacher was elevated to coach.

The season is over and Coach joined us at the morning round table last week, attempting to dissipate his depression onto the rest of us. "We didn't have too many big boys—Junior Herndon was the biggest at 210 pounds and only 5′9″ But the enthusiasm," said Coach brightening up a little bit, "was spectacular in the locker room. Everybody would butt into Junior, pound each other on the shoulder pads, bang their helmets into the lockers. Cries of 'Let's go get 'em' and 'Hit someone' came out of the locker room, demonstrating the fierceness of our team."

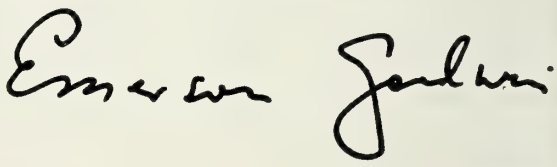
Then the blanket of remorse settled over the coach again when he went on. "When that fierce-appearing team got out on the field, you all know what happened. They shied away from the opponents, dodged the contact, just didn't seem interested in playing the game. I just couldn't understand it; and this morning I got the answer from, of all people, Junior Herndon."

Everybody brightened up. Finding the answer was a revelation. We were all equally discouraged and disappointed by our abysmal season.

The revelation? What Junior Herndon said was, "In the locker room we could make a lot of noise and everybody enjoys that, but out on the field you could get hurt!"

It seems to me that you folks got all the locker room enthusiasm that you need. You're all beatin' each other on the shoulders and you got the right equipment. What Junior said is true, "You could get hurt out there."

As an observer, I'm gonna watch with interest to see what your team does when it charges out of the locker room. If all members come out ready to do their part for your team, willing to hit and if necessary to take a few lumps, then I am sure you will succeed. However, I am equally sure that locker room histrionics and conversation just won't win on the field. ◀



Regards
Emerson Goodwins

Angina comes in many forms...

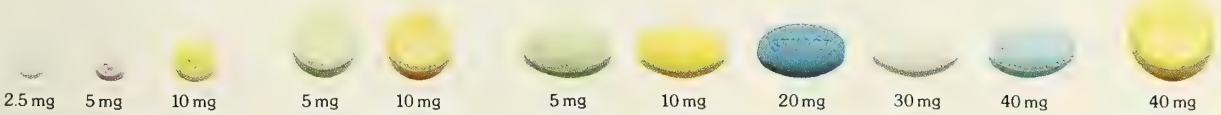


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5 mg 10 mg 20 mg 30 mg 40 mg
Oral "Swallow" Tablets

40 mg
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See following page for brief summary of prescribing information.

SORBITRATE®
(ISOSORBIDE DINITRATE)

Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks. Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis.

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites. Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established. If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension.

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE. The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy.

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary.

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur. Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory. The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined. However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals. On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months.

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers. In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal. The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly.

Information for Patients: Headache may occur during initial therapy with SORBITRATE. Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use.

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates.

Isosorbide dinitrate acts directly on vascular smooth muscle; therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug. A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet.

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose. There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman.

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established.

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related. In clinical trials at various doses, the following have been observed.

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent. Cutaneous vasodilation with flushing may occur. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur. Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg; for oral (swallowed) tablets, 5 to 20 mg; and for controlled-release forms, 40 mg.

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose. In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure.

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours. Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported.

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended. The extent to which development of tolerance should modify the dosage program has not been defined. *The oral controlled-release forms of isosorbide dinitrate should not be chewed.*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg), Chewable Tablets (5, 10 mg); Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg).

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Housestaff News

(Continued from page 96)

tion, and social needs of chronic-care patients." Although not adopted, the resolution received enthusiastic response and was referred back to the RPS and MSS for further study. Subsequently, a resident/medical student task force was established to study this issue in conjunction with the Chicago Geriatric Society committee.

Based on surveys of residents and medical students at the 1983 and 1984 annual AMA meetings conducted by the ISMS-RPS, most respondents desired more chronic-care and geriatric instruction in medical school focusing on physical, social, and psychological topics. Of those who had adequate training, a multidisciplinary approach, whether by formal classroom instruction or informal seminar sessions, seemed most effective. Although most respondents had an awareness of senior citizen population growth, about 75% underestimated their responses to questions concerning future trends in growth by age group, nursing home population, and in health-care expenditure. Interestingly, about 66% were not familiar with chronic care legislation in their own states.

Anticipating an environment which will inevitably place greater emphasis on care for the aged and chronically ill will result in better patient management and understanding, and hopefully avert an economic crisis. Changes will be necessary, as hospitals, HMOs, nursing homes, and visiting home health care agencies all compete to most economically deliver the best health care. Physicians and other health care professionals, involved lay people, and the elderly themselves are among those who will be pivotal to these changes.

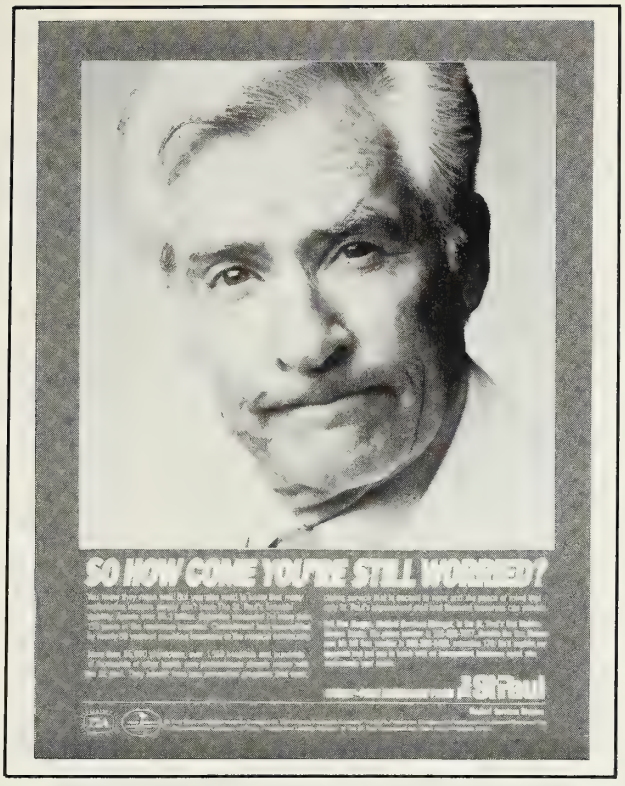
An educated approach to this metamorphosis in health care needs will require basic and multileveled instruction in geriatrics. Enhanced media attention and public awareness of our society's changing medical needs is critical. With the assistance of government agencies and the understanding of a sympathetic and empathic public, man and medicine can age in harmony. ◀

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*Additional NMR Information on page 134

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Aeromonas Hydrophila Infection in the Hand

By Victoria R. Masear, M.D. and James J. Hill, Jr., M.D./Springfield

Aeromonas hydrophila has not been previously isolated from Illinois waters. We report a case of Aeromonas hydrophila hand infection resulting from an underwater injury sustained in stagnant overflow from the Illinois River. A. hydrophila is similar to the Enterobacteriaceae, but can be distinguished from them by its positive oxidase reaction. Aeromonas hydrophila should be suspected in soft tissue injuries incurred under aquatic conditions. In a healthy host these infections usually respond rapidly to surgical debridement, irrigation, and appropriate antibiotic coverage.

We report a case of Aeromonas hydrophila infection of a hand wound sustained in water from the Illinois River. To our knowledge this organism has not previously been reported in Illinois. Aeromonas hydrophila has been isolated from many regions of the world, including Denmark, Sweden, India, Bangladesh, Yugoslavia, Israel, Puerto Rico, the Canal Zone, and various parts of the United States. Most commonly, the organism has been found in the southern and eastern states of the U.S. Hazen, *et al.*, tested 147 natural aquatic habitats in 30 states and were able to isolate the organism in all but 12 sites in five states.[1] The sites where Aeromonas hydrophila could not be found included two hypersaline lakes, two geothermal springs with temperatures greater than 45° C, and three extremely polluted rivers. Two of these polluted rivers not yielding A. hydrophila were the Mississippi River and one of its Illinois tributaries, the Wabash River.

Aeromonas hydrophila is a motile, gram-negative, monotrichous, polarly flagellated bacillus that is nonfastidious and facultatively anaerobic. A. hydrophila species has been variously described as belonging to either the family Pseudomonadaceae or Vibrionaceae.[2-4] The genus Aeromonas includes four species: hydrophila, punctata, liquefaciens, and salmonicida.

The primary habitats of A. hydrophila are soil, water, and nonfecal sewage with a high content of organic substances.[5,6] It has been primarily isolated from nonhuman sources including lakes, rivers, tap water, fish, reptiles, amphibians, and soil. It has been commonly isolated from stagnant water.[3,7] (Table 1)

A. hydrophila is usually considered an opportunistic pathogen in humans with the majority of septicemic patients having impaired host defenses secondary to neoplasia (usually leukemia) or hepatic disease.[4,5,8-11] The infection is often fatal in these patients. It is an increasing cause of nosocomial septicemia in immunologically compromised hosts, leading to gastroenteritis, septicemia, meningitis, pneumonia, and surgical wound infections.[2] (Table 2)

Case Report

A twenty-two year old man presented with pain and swelling of his right hand two weeks after sustaining an underwater injury. The dorsum of his right hand over the thumb and index web space had been punctured by a catfish fin while "logging" for catfish, which involved catching the fish with his hand. Over the preceding week he had developed pain, swelling, and redness around the puncture site.

The patient was afebrile and not acutely ill on presentation. Examination revealed a two-by-three centimeter bluish gray bullous lesion over the dorsum of the thumb and index web space. Moderate swelling and erythema were evident over the first dorsal interosseous region. There were no palpable epitrochlear or axillary lymph nodes. White blood cell count was 7,100 and the

Table 1
Sources of A.hydrophila isolates

Tap water, hospital water, swimming pools[4,5]
Human feces[5,14,20]
Sputum, trachea, throat[13,14]
Skin[20]
Bloodstream[13,14]
Fish, amphibians, turtles, alligators, snakes[8,14,16]
Abscesses, cellulitis[8,13]
Urinary tract[8,13]
Soil[4,5,14,16]
Rivers, streams, lakes[2,4,5,13,14]
Bile, gallbladder[5,13,14]
Surgical and traumatic wounds[5,13,14]
Stasis and decubitus ulcers[5]
Exudate from otitis media[5]
Bone
Canned foods[4,14]
Feces of mice and guinea pigs[14]
Skunks, poultry, cattle[14]
Eggs[16]
Bovine placenta[13]
Drainage pipes, sewage[4]
Pleural fluid[13]
Ascitic fluid[13]
Arthritic exudate
Spinal fluid
Dialysis tubing[20]

erythrocyte sedimentation rate 18mm/hr.

Under intravenous regional anesthesia, the lesion was incised and drained of serosanguinous fluid. Irrigation and debridement was followed by packing of the first dorsal interosseous compartment with iodoform gauze. After cultures of the wound had been taken, intravenous cefazolin therapy was begun and continued for forty-eight hours. Cultures by that time had identified Aeromonas hydrophila, distinguished from Enterobacteriaceae by its positive oxidase reaction. The organism was sensitive to tetracycline and the antibiotics were then changed to oral tetracycline, 250mg, four times daily. On the third postoperative day the wound was without erythema or drainage and delayed closure was carried out. The wound healed without incident and the tetracycline was discontinued after one week. There was no evidence of recurrent infection at last contact six months postoperatively.

Discussion

Although epizootics in fish caused by Aeromonas hydrophila have been mainly concentrated in the Southeastern United States, the organism has been isolated in many parts of the country. Previous tests of Illinois waters have not revealed A. hydrophila,[1] but the patient reported here did contact the organism in stagnant water overflow from the Illinois River.

Hazen, *et al.*, found a much higher density of A. hydrophila in saline than in fresh water habitats.[1] The density was also higher in flowing than in still water systems. The organism could not be isolated from extremely saline, thermal, or polluted water. Shotts, *et al.*, felt that abundant accumulation of nutrients that support dense plant and animal life and a low dissolved oxygen content of water were factors predisposing to Aeromonas hydrophila infection in fish and reptiles.[12]

The primary culture of A. hydrophila is accomplished on the usual laboratory media (blood agar, enteric differential agars, and tryptic digest broths). It is usually betahemolytic on blood agar.[3] A. hydrophila can be easily misidentified because of its similarities both morphologically and biochemically to the Enterobacteriaceae, notably E. coli and Serratia.[2] Tests for the oxidase reaction and carbohydrate fermentation are the most important steps in distinguishing A. hydrophila from the Enterobacteriaceae and nonfermentative gram-negative rods. A. hydrophila ferments carbohydrate and gives a strongly positive cytochrome oxidase test, while the Enterobacteriaceae are oxidase negative.

A. hydrophila is pathogenic to many fresh and salt water species. It has been found in fish, turtles, alligators and snails.[1,12] It causes red leg disease in frogs; septicemia and stomatitis in snakes, salamanders, and lizards; black rot in hen eggs; and has also been implicated as a cause of abortions in cattle.[3-5,12,13]

Table 2
A.hydrophila manifestations in humans

Traumatic wound infections[2,8,17,19]
Cellulitis[3,4,10,13,17]
Septicemia[3,4,8,11,17,19,20]
Ulcerated skin
Diarrhea, gastroenteritis[3,4,11,13,16,17]
Osteomyelitis[4,7,13,18,19]
Necrotizing myositis[4,5,13,19]
Endocarditis[3,19]
Meningitis[3,4,13,19]
Peritonitis[3,4,11,13]
Bronchitis, pneumonia[4,8,13]
Urinary tract infection[3,4,8,17]
Septic arthritis[4]
Transfusion reaction[4]
Scrotal gangrene[4]
Pharyngitis, tonsillitis[4]
Surgical wound infections[3,4]
Hepatic abscess[4]
Cholangitis, cholecystitis[4,11]
Gangrene of bowel
Otitis[3]
Hepatitis[11]

Rodents, dogs, cats, pigeons, and fowl have been infrequently identified with A. hydrophila infection.[14]

A. hydrophila has the unusual ability to infect both cold and warm-blooded organisms.[15] Hazen, *et al.*, were not able to isolate A. hydrophila at temperatures greater than 45°C.[1] Its thermal optimum is 30-35°C but it can tolerate a temperature range of 4° to 40°C.[3,4,16] Many warmwater fish species are exposed to thermal optimum temperatures for A. hydrophila during late spring, summer and early fall. This may account for the propensity of isolates from humans between the months of May and September.[6,9]

A. hydrophila may be endogenous to the human intestinal tract, having been isolated from feces in up to 3.2% of healthy subjects tested.[17] It is a potential intestinal pathogen in humans associated with diarrhea and gastroenteritis.[8,16] The diarrhea is usually moderately severe and self-limiting. Most reporters believe A. hydrophila septicemia originates in the large intes-

tine.[11,18] A possible portal of entry into the circulation is intestinal ulceration caused by antimetabolite therapy, leukemic infiltration or fungal implants in the intestinal mucosa.

A. hydrophila infections of skin and soft tissues rank second in frequency to gastrointestinal infections.[5,19] Soft tissue infections usually remain localized in healthy hosts. Those with occupations such as fishing or wading in wet fields are most prone to infection. Characteristically there is a rapidly evolving cellulitis and/or pustular eruption following a soft tissue injury sustained under water.[2,19] The local inflammation and suppuration may be accompanied by moderate fever and leukocytosis.

The mainstay of treatment is debridement, irrigation, and antibiotics.[4] This leads to rapid healing of the majority of A. hydrophila soft tissue infections in healthy hosts.[2,6,8,17,19] Chloramphenicol and tetracycline are usually the drugs of choice for A. hydrophila infection, but a bactericidal drug such as kanamycin should be substituted in cases with sepsis. Tetracycline, kanamycin, nitrofurantoin, nalidixic acid, sulfonamide, gentamicin, chloramphenicol, tobramycin, and neomycin are consistently effective. Uniform resistance is found to penicillin, ampicillin, and carbenicillin.[3,4,8,10,15,17]

Summary

Soft tissue injuries occurring under aquatic conditions or contaminated with soil should raise suspicion for potential Aeromonas hydrophila infection. This facultatively anaerobic, gram-negative, motile bacillus with polar flagellation resembles the enteric bacilli. The key to identification is the performance of the oxidase test. The major difference from the Enterobacteriaceae is the production of oxidase and polar arrangement of flagella in A. hydrophila. Debridement, irrigation, and appropriate antibiotic therapy for A. hydrophila soft tissue infection usually give good results in the uncompromised host.

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In A Pregnant Patient with Chronic Osteomyelitis

Ultrasonographic Confirmation of a Thigh Abscess

By Charles R. B. Beckmann, M.D., Jessica L. Thomason, M.D., Milo B. Sampson, M.D. and Ellen E. Sheets, M.D./Chicago

Osteomyelitis is an unusual complication of pregnancy. Three cases have been previously reported, two of which were hematogenous osteomyelitis diagnosed in the postpartum period.[1,2] The third involved chronic osteomyelitis in the right femur of a 22 year old G3P2 who experienced exacerbation with abscess formation during pregnancy. She was treated conservatively with traction of the limb and was delivered vaginally at term of healthy twins.[3] We present a fourth case where ultrasound was used to confirm the diagnosis of an abscess secondary to chronic osteomyelitis in a pregnant patient.

A 22 year old black G2P1 presented at 37 weeks gestation complaining of a swollen painful left thigh. Her antenatal course was characterized by poor nutrition, anemia and poor fundal height growth. At twelve years of age she had undergone open reposition of a left hip dislocation. A flexion contracture had developed requiring open soft tissue release two years later, and again the following year. Because of continued disability, a total hip arthroplasty was performed the following year. The prosthesis became infected, requiring surgical drainage and debridement, with cultures growing coagulase positive *Staphylococcus aureus.* Chronic osteomyelitis ensued. After three hospitalizations with conservative therapy the prosthesis was removed two years after its placement. Three years later, while pregnant, swelling and pain of her left hip and thigh was severe enough to cause hospitalization on two occasions, although no specific therapy for osteomyelitis was instituted.

On admission a raised, tender, warm mass approximately 14 by 15 centimeters was found on the anterior surface of her left thigh. The patient had decreased left hip mobility. Initial evaluation included a Hbg-Hct of 8.1/33.6 with a negative sickle cell preparation, reticulocyte count of 1.7, Fe/TIBC of 17/474, and ESR of 58. Fetal well being studies showed a healthy fetus whose obstetric ultrasound was consistent with dates. A "mature" L/S ratio of 2.2 was obtained by amniocentesis. A radiograph of the left hip and thigh (Figure 1) showed bony and periosteal evidence of chronic osteomyelitis and the sequellae of her previous surgery. Surgical and infectious disease consultation was obtained which favored a diagnosis of chronic inflammatory reaction or hematoma rather than abscess. Ultrasound of the left thigh was then obtained to facilitate diagnosis from this differential, revealing sonolucent areas consistent with abscess cavities (Figure 2). Needle aspiration of the superficial cavity produced 180cc of pus from which coagulase positive *Staphylococcus aureus* sensitive to nafcillin was grown. With the diagnosis of abscess and the knowledge that the ultrasonically identified deep abscess cavity had not been drained, intravenous nafcillin therapy was initiated and surgical drainage and debridement were performed. Intraoperative and postoperative fetal well being studies were satisfactory. With a

favorable Bishop's score of six on the ninth postoperative day, induction of labor was performed with the vaginal delivery of an 2100gm SGA male infant without infection. Mother and infant were discharged in good condition on the sixteenth postoperative day.

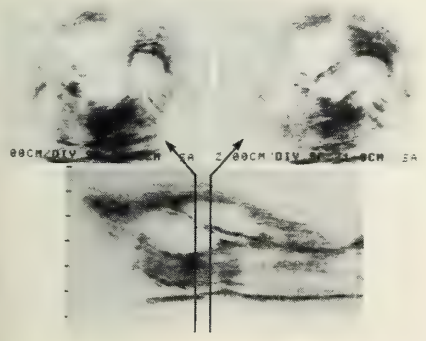
Discussion

The diagnosis of osteomyelitis involving the pelvis and hips is difficult. This is due to the indolent nature of this infection and its relatively deep location within the body, which can delay diagnosis until localizing signs become quite prominent.[4] With concurrent pregnancy, fear of fetal radiation exposure and dissemination of infection to the fetus compounds the difficulty in fulfilling two of the three criteria suggested by Waldvogel as necessary to confirm the diagnosis: the characteristic radiographic changes involving bone and periosteum, pathologic verification on bone biopsy, and bacteriologic corroboration.[5]

Figure 1. Radiograph of the left hip and femur demonstrating changes consistent with chronic osteomyelitis and the patient's previous surgery.



Figure 2. Two transverse and one longitudinal ultrasound views confirming and localizing the thigh abscess secondary to chronic osteomyelitis.



In this case a differential diagnosis including abscess secondary to chronic osteomyelitis, hematoma, and chronic inflammatory reaction was suggested. Ultrasound of the thigh was then used to confirm the diagnosis of abscesses and to localize their positions, allowing pus to be aspirated from the superficial cavity from which *Staphylococcus aureus* sensitive to nafcillin was grown. This allowed final confirmation of the diagnosis and established the appropriate antibiotic therapy. *Staphylococcus aureus* is the predominent pathogen in about one-half of cases of chronic osteomyelitis complicating orthopedic surgery, although mixed infections with gram negative organisms (especially *E. coli*) are common in pelvic osteomyelitis. A combination of surgical drainage and debridement and antibiotic therapy is required to effectively treat such infections,[5] as in this case, where preoperative antibiotic coverage and transfusion, general anesthesia with good oxygenation, and intraoperative electronic fetal monitoring allowed successful treatment of the infection and eventual delivery of an uninfected infant. Ultrasound evaluation of the thigh mass facilitated the timely identification of the abscess and its subsequent management. ◀

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Impact of Two New Imaging Modalities

Diagnosis of Syringomyelia

By Steven J. Smith, M.D., Mark Greenberg, M.D., Robert L. Vogelzang, M.D., Brent Greenberg, M.D., Harvey L. Neiman, M.D. and Irving Greenberg, M.D./Chicago and Highland Park

In recent years there has been a literal explosion of new imaging technologies. Nowhere has this change been more evident than in the diagnosis of central nervous system disorders. Computed tomography (CT) is now the imaging method of choice for the brain and along with myelography can diagnose most conditions in and about the spinal cord. Magnetic resonance imaging (MRI), however, has shown great promise in supplanting CT as the primary diagnostic tool for both brain and spinal cord. We report a case in which these two new imaging modalities (MRI and intraoperative ultrasound) were able to conclusively establish the diagnosis of syringomyelia and monitor its surgical therapy.

The patient was a 19-year-old white male with a three year history of clumsiness in both hands which had slowly progressed to frank weakness. Neurological examination at admission showed slight distal arm weakness on the left and right. Arm reflexes were absent and sensation to pin prick at C_5 through C_8 bilaterally was decreased. Some atrophy of the distal upper extremity musculature was also seen and the Babinski examination was negative. Metrizamide enhanced CT of the cervical and upper thoracic area showed cord widening. There was no filling of the widened cord on 24 hour delayed views (Figure 1). MRI examination using a .05 Tesla resistive magnet and spin echo parasagittal imaging demonstrated a central cavity with low signal intensity in the cervical cord associated with a Chiari type I malformation (tonsillar herniation) (Figure 2).

Based on the CT and MRI findings, lower cervical-upper thoracic laminectomy was performed at which time a bulging, tense lower cervical cord lacking normal pulsations was found. Intraoperative ultrasound was performed as an aid to localization and characterization. This showed an irregular anechoic fluid-filled central compartment within the cervical and upper thoracic cord with some internal strands or septations typical of a syrinx (Figure 3). Laser fenestration at the T_1 level provided good decompression of the entire syrinx which was demonstrated by a post-fenestration ultrasound (Figure 4).

Comment

Standard film and CT metrizamide myelography are currently the most commonly used methods to diagnose syringomyelia. MRI, however, has distinct advantages over both of these modalities in terms of its ability to differentiate spinal cord from surrounding spinal fluid, as well as its ability to image the entire cord in a sagittal plane. Modic, *et al.*, have described the advantages of MRI over metrizamide CT and refer to it as "the examination of choice in the diagnosis of syringomyelia malformation."[4] In their opinion, MRI demonstrated superior definition of the syrinx when compared to CT, (mainly based on the ability to image the lesion in the sagittal plane) better delineation of the craniocaudal extent of the lesion, absence of ionizing radiation, and ability to perform the examination on outpatients. Additionally, the use of MRI avoids the well known and significant neuropsychiatric side effects of intrathecal metrizamide.[5] Although experience with MRI of syrinx is limited, most authors feel that MRI will allow positive confirmation of syrinx in that group of patients who fail to opacify a syrinx on metrizamide CT. MRI is also likely to differentiate necrotic tumor from a true syrinx.[4,6]

Intraoperative ultrasound is a recent development made possible

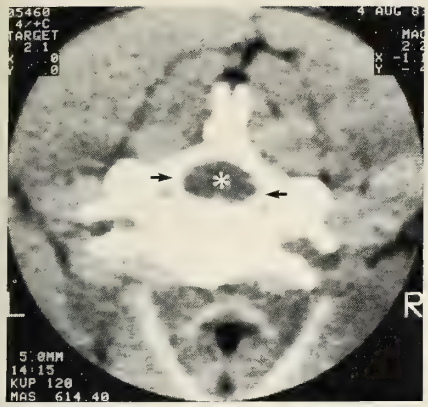


Figure 1
Prone metrizamide enhanced CT at C_6. Note widened cervical cord () surrounded by subarachnoid metrizamide (arrows).*

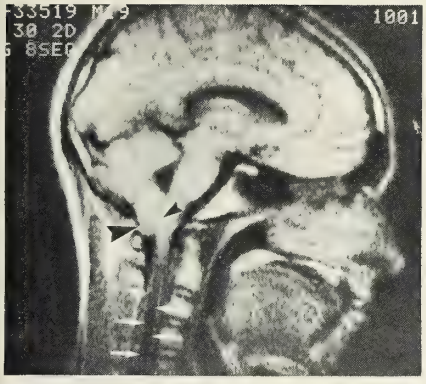


Figure 2
Midline sagittal spin echo magnetic resonance image of the upper cervical spine. Cervical syrinx (arrows) seen as a low signal intensity (black) central cervical cord lesion. Also, note cerebellar tonsillar herniation (arrowheads).

by the use of portable real-time sector scanners.[7,8] Extensive experience is currently being accumulated in the use of this modality in surgery of deep brain masses. The use of intraoperative ultrasound of the brain allows for more precise localization of the lesion. Ultrasound-guided direct needle biopsy can also be easily performed with significant reductions in operative time and tissue damage. The technique has also been applied to lesions of the spinal cord in which tumors of the cord can be easily differentiated from syringomyelia. In addition, monitoring of the adequacy of excision of tumor or decompressed syrinx is afforded.[9,10]

In our case, the clinical history was suggestive of syringomyelia but conventional metrizamide CT showed only cord widening without the diagnostic finding of delayed penetration of metrizamide into the syrinx cavity. Sagittal MRI, however, showed the fluid-filled syrinx to superb advantage, as well as the previously unsuspected Chiari malformation.

Laser fenestration of syringomyelia involves localization and exposure of the syrinx followed by decompression when a small hole is burned in the dorsal cord. Intraoperative ultrasound in our case effectively imaged and characterized the syrinx. The lesion in this case was well-seen, some apparent internal septation was noted, and a suitable site for laser fenestration was localized. After the procedure but before closing the soft tissues, ultrasound examination showed complete disappearance of the fluid-filled cavity.

Conclusion

Two new developments of neurological imaging, magnetic resonance and intraoperative ultrasound, are beginning to be widely applied in the routine diagnosis and treatment of the central nervous system. In this particular case, magnetic resonance imaging allowed a positive preoperative diagnosis when conventional CT metrizamide myelography had failed to absolutely confirm the diagnosis. Intraoperative ultrasound was very helpful in defining the extent of the syrinx and confirming adequate laser fenestration. These two new modalities show great promise and undoubtedly will become primary imaging tools in the diagnosis and treatment of central nervous system lesions. ◀

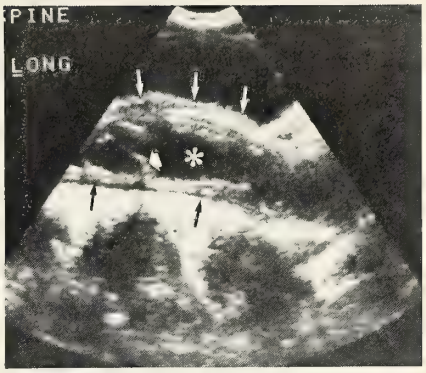


Figure 3
Longitudinal intraoperative ultrasound of the lower cervical cord. The patient's head is to the viewer's left. Widened cervical cord (arrows) with central echo-free syrinx (). Internal septum also noted (arrowhead).*

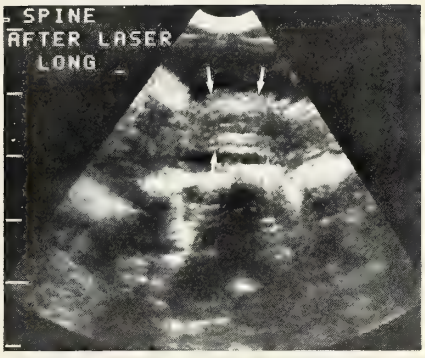


Figure 4
Longitudinal intraoperative ultrasound of the cervical cord post-fenestration. Note complete collapse of syrinx and a decrease in cord (arrows) size when compared with Figure 3.

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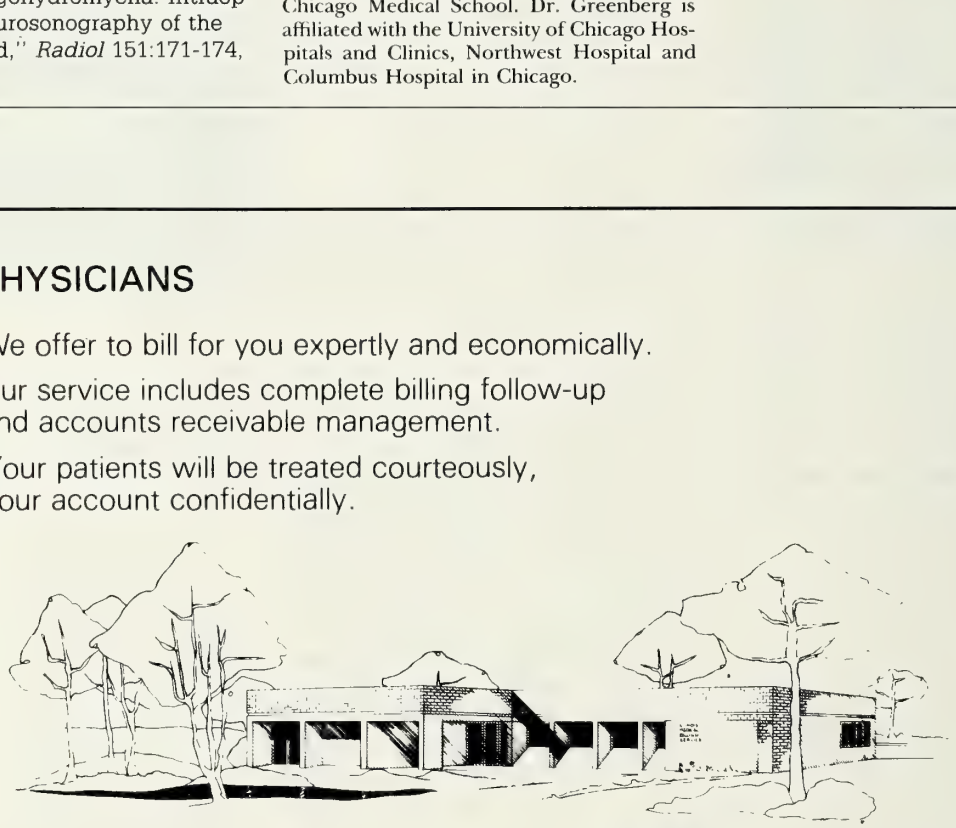
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Muscle Syndromes, Part II

Fibromyalgia (Fibrositis)

This is the second of a series of articles for the Rheumatology Rounds column focusing on muscle syndromes. Part one, which focused on polymyalgia rheumatica, was published in the April, 1984 issue of IMJ.

A 40 year old black female was seen for evaluation of suspected SLE. The patient related a multi-year history of chronic musculoskeletal aches and pains diffusely about the body. Persistent pain was reported in the neck and occiput area. Chronic headaches were always present, mostly frontal and bilateral. Numbness was noted about all five fingers with radiation of symptoms to the elbow, leaving a sensation of coldness. Numbness was precipitated by use, not cold, and was without color change. The fingers often felt swollen. Lateral thigh numbness was a frequent complaint, unrelated to position or exertion. Elbows, shoulders, knee and foot pains were intermittently present, lasting hours to days, often moving about. At no time did the patient describe herself as free of pain. Symptoms were made worse by menstruation and exertion but seldom relieved by rest.

The patient noted poor energy and difficulty sleeping. She awoke stiff, aching, and unrefreshed. She denied fever, mucosal ulcerations, alopecia, rash, dry mucosa or weight loss. Recent evaluation had revealed a positive antinuclear antibody and led to a suspected diagnosis of systemic lupus erythematosus. Trials of nonsteroidal antiinflammatory agents and prednisone were without effect. Symptoms had becomed so disabling that she was unable to work.

The patient was currently taking ibuprofen. Pentazocine, propoxyphene, meperidine and phenobarbital, all tried for her symptoms, had produced non-specific adverse reactions. Past history included dilatation and curettage and tubal ligation after three uncomplicated pregnancies. Review of systems included a recent, unrevealing gastrointestinal work-up for chonic constipation and abdominal pain. Psychiatrically, she related a fear of illness, poor sleeping habits, and little joy to life but was without suicidal ideations.

On examination, vital signs were unremarkable. Skin was without lesions. Fingertips were soft and unscarred. Emersion of hands in cold water revealed no color change suggestive of Raynaud's. On musculoskeletal evaluation, tenderness was noted to palpation about the trapezius, pectorals, lateral thigh, and over the sternal area. All joints had normal range of motion without evidence of swelling, redness or heat, but elicited tenderness throughout the range of motion and on direct palpation. Strength and reflexes were normal in both upper and lower extremities proximally and distally. Tinel's sign was negative. Other examination, including chest, abdomen, neck, nodes and breast exam, was unremarkable.

CBC, platelet, SMA-18, urinalysis, EKG, and chest x-ray were unremarkable. Sedimentation rate was 23mm/hr (Westergren). CRP was zero. Antinuclear antibodies revealed a positive speckled pattern at 1:20; antiDNA, antiENA, SSA, SSB, and rheumatoid factor antibodies could not be detected. Complement levels were normal. Circulating immune complexes as measured by cryoglobulins, CIQ and Raji cell assays were not present. Skin biopsy for immunofluorescence was unrevealing. X-rays of the cervical spine were normal. An EMG of the hands was negative for evidence of radiculopathy, peripheral neuropathy, and carpal tunnel. A bone scan did not reveal uptake about any joint.

Discussion

Fibromyalgia (fibrositis) describes a clinical syndrome of chronic nonarticular musculoskeletal aches and pains in multiple areas of the body, associated with tenderness to palpation over predictable sites. It has been noted to be one of the most common of rheumatic syndromes, occurring in up to 20% of patients seen in rheumatologic practices. It remains a constant source of major disability and morbidity to patients and of continuing frustration to physicians. Recently, clinical studies have helped to better define what has always been a common but poorly delineated illness.[1]

Pain is the most common complaint related by the patient, often described as a throbbing or a deep ache or stiffness. Symptoms may be transient, lasting hours to days and often migrating from one site to another. On occasion, one site may predominate. Most patients, despite the migration, will at any one time

complain of multiple current sites of involvement and rarely have symptomless periods. Usual sites of pain include the low back, trapezius muscles and paracervical areas, gluteal and greater trochanteric areas about the hips, medial and lateral condyles and ligaments of the elbows and knees, temporomandibular joints, and costochondral junctions. Arthralgias about small joints of the hands and feet are often noted. Associated symptoms include numbness, tingling, burning, or weakness of extremities. A subjective sensation of swelling may occur in the extremities. Direct palpation of these areas is painful, with tenderness to light touch leading to facial grimaces or withdrawl (jump sign). Despite multiple years of persistent symptoms, examinations of muscle, nerves and joints are unrevealing except for the local tenderness, which is the single best clue to diagnosis. The absence of objective signs in the presence of such severe symptoms over a prolonged period of time should point the physician toward the diagnosis of fibromyalgia.

There are many constitutional symptoms: exhaustion, tiredness, poor energy, weight gain despite decreased appetite and complaints of chills or sweats suggesting fever. Symptoms are often precipitated by cold, humidity, tiredness, excessive exertion, disuse, emotion, anxiety, alcohol or menstrual cycle. Rest, heat, mild exercise or vacations are often palliative. Associated illnesses have been noted to be chronic disabling headaches (tension or migrainous), irritable bowel syndrome, or chonic chest wall syndromes. Laboratory evaluation, including rheumatoid factor, antinuclear antibody, sedimentation rate and CBC are all within normal limits. There are no specific diagnostic clues to the syndrome aside from the typical history and examination and the absence of other illnesses. While usually primary, the illness may be seen secondary to trauma or as persistent symptoms in an otherwise controlled inflammatory arthritis such as rheumatoid arthritis. The cause remains unclear: no site of inflammation in muscles, ligaments, tendons, joints, nerves or subcutaneous tissue has ever been demonstrated. Trigger points, much heralded as a diagnostic clue, are hard to reproduce between observers, and pathologically have not been shown to represent inflammatory tissue.

The relationship of the fibromyalgia syndrome to depression and sleep disorders is of continuing clinical and research interest. Patients are often clinically depressed, requiring therapy. Whether such illness is a result of the chronic disability and pain these patients experience, or is part of the underlying illness, is unclear. How much such depression adds to the patient's symptoms is also unclear. Attempts to define a "fibromyalgia" personality have revealed conflicting results in terms of depression scales.[2] What seems clear to most rheumatologists, however, is that this is not a psychosomatic or malingerer's illness, but rather a chronic pain syndrome of undefined cause. A sleep disorder has been found by some researchers, consisting of disturbance of stage four nonREM sleep.[3] Induction of this sleep abnormality in normal volunteers can precipitate fibromyalgia-like symptoms, and treatment of the disturbance with tricyclic antidepressants may help symptoms in some patients. While the role of this sleep disturbance in fibromyalgia remains unclear, patients often complain of nonrestorative sleep with early wakening and poor energy upon arising, and may benefit clinically from mild sedation by tricyclic antidepressants at night.

Therapy includes nonspecific analgesics such as nonsteroidal antiinflammatory agents, and attempts at physical modalities for relief of pain on a trial and error basis. Rest, heat and mild exercise in various combinations may be useful. Injections of xylocaine and/or steroids in subcutaneous areas may give relief, as may transcutaneous nerve stimulation or acupuncture. Psychoactive drugs such as tricyclic antidepressants may be used for concomitant depression or sleep disorders. Avoidance of addictive narcotics, or analgesics with potential for abuse or long term toxicity is crucial. Systemic steroids seem to have no role in this illness. Discussion with patients about the nature of fibromyalgia and its benign prognosis in terms of physical destruction of joints may be helpful. Patients often fear that excessive use of painful areas may result in tissue damage, and reassurance that temporary pain is the only consequence of such exertion may aid them in dealing with their illness. In fact, moderate amounts of use consistent with as normal a lifestyle as possible are to be strongly encouraged, as patients must attempt to function despite their symptoms.

Conclusion

The chronic and diffuse nature of the pain, together with absence of objective physical signs of illness except tenderness to palpation, suggested fibrositis in the present case. Multiple normal laboratory tests seemed confirmatory: low titered speckled ANA was considered normal for the specificity of the test, and other SLE tests were negative. The patient demonstrated several of the associated syndromes of fibrositis: poor sleep, chronic bowel and headache syndromes, and multiple constitutional symptoms, which supported the diagnosis. She was begun on amitriptyline and outpatient physical therapy consisting of daily heat and mild exertion was instituted. Diflunisal and a TENS unit were given for her pain. A high roughage diet was begun for her constipation and supplemented with stool softeners on a PRN basis. Although unable to return to work, she has had variable improvement in her symptomatology, with occassional periods of significant relief.

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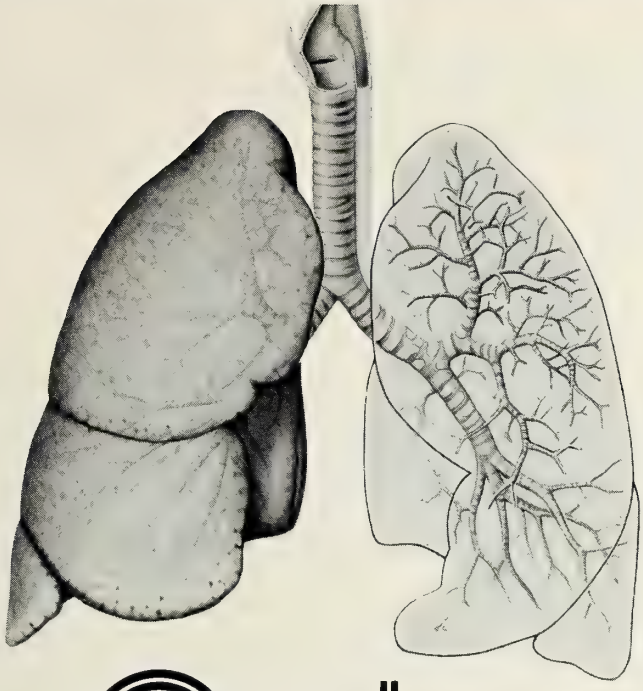
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Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible orgahisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor® (cefaclor, Lilly) have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

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Note. Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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An Open Letter From the AAMA Physician Advisors

Dear Doctor:

This letter is to acquaint you with the benefits available to your office personnel through the American Association of Medical Assistants. For those of us who have enjoyed a long relationship with this association, the cost-savings provided by a higher level of professional competence among our assistants have far out-stripped the modest costs of supporting their membership.

The AAMA is a professional association, formed 31 years ago. It is a tri-level organization for individuals who work under the supervision of physicians, in the physician's office, hospitals or other facilities, performing administrative and/or clinical duties. Its national, state and local chapters are doorways to professionally directed programs, designed to improve the abilities of your assistants in the delivery of health care. The AAMA is a nonprofit organization. It is not, nor shall it ever become, a trade union or collective bargaining agency. The AAMA is generously endorsed by the AMA and the ISMS and we fully endorse the programs and functions of the AAMA.

A medical assistant is defined as anyone who works under the supervision of a physician licensed to practice medicine, and AAMA membership is open to receptionists, secretaries, bookkeepers, nurses, technicians or any person assisting within your range of supervision.

Continuing education is the main objective of AAMA. There is ready access to state and nationally sponsored programs, including self-study courses and advisory help. Education classes are held regularly, and lectures are conducted by physicians and other professionals supporting the practice of medicine.

Group life, medical, long-term disability and professional liability insurance is available to members at reduced premiums. AAMA also encourages advancement of medical assistants by offering a Certification Examination designed to recognize professional competency.

There is a local chapter of AAMA near you that meets monthly, usually in the evening. At these meetings medical assistants learn new capabilities and enjoy the fellowship of their co-workers in the community.

Dues currently are $66.00 for state and national. Chapter dues vary from $5.00 to $10.00. Dues are payable yearly on January 1. The dues include membership on the county (chapter), state and national levels and state and national educational periodicals.

In supporting the AAMA, by enrolling your medical assistant in the local chapter, you will be supporting your own practice of medicine in a highly professional manner.

American Association of Medical Assistants, Illinois Society, Physician Advisors

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Robert R. Hartman, M.D., ISMS Liaison
Thomas P. Harwood, M.D.
Leslie Schwartz, M.D.
Peter C. Lee, M.D.
Robert E. Thompson, M.D.
Jack Chandler Berger, M.D.

Further information about the Illinois Society, AAMA, may be obtained by contacting one of the officers: Anna Cannon, president, 7443 S. Luella, Chicago IL 60649; Betty J. Kronemeyer, CMA, immediate past president, 809 N. 10th, Mascoutah IL 62258; Ehlma Garcia, CMA-EMT, president-elect, 6134 S. Tripp, Chicago IL 60629; Cheryl Hutchison, CMA, first vice president, 53 Lockhaven, Granite City IL 62040; or Betty Jean Meier, second vice president, 2812 Barber Green Road, DeKalb IL 60115.

Restoring Balance

The rapidly worsening malpractice problem has been the focus of a major initiative for legislative reform by the Illinois State Medical Society (ISMS) and the Illinois State Medical Inter-Insurance Exchange (ISMIE). The multi-faceted malpractice initiative is by far the most intensive legislative program conducted by ISMS and ISMIE since the "malpractice crisis" of the mid 1970s.

To give physicians some perspective on the scope of the problem and the profession's efforts to resolve it, IMJ *recently interviewed Dr. Robert C. Hamilton. Dr. Hamilton is the president of ISMS, and a member of the board of directors of Illinois State Medical Insurance Services, Inc., which is the ISMS subsidiary that manages the operations of ISMIE.*

IMJ: ***The term "malpractice" seems to have different meanings for different people. As a physician, how would you define it?***

Dr. Hamilton: True malpractice is just what it says. It means bad practice. It can be in any profession, whether it's law, medicine, or architecture.

IMJ: ***If malpractice means bad practice, does it follow then that the malpractice problem is really one of many doctors practicing bad medicine?***

Dr. Hamilton: No, not at all. Even excellent care may not provide the ideal results. When dealing with human beings, no one can assure a 100% result. And in the society in which we live, people's expectations are high. When any result is less than 100%, they may feel that a mistake has been made and that someone should pay for it. It's the same way with product liability and auto accidents.

It's not only bad doctors who have malpractice situations. Malpractice can result from a complication which is inherent in a medical or surgical procedure. Even the best doctors cannot always be assured of having perfect results.

But people see the good and the excellent results publicized. They're less aware of the fact that there can be disappointing results and complications in the best of hands. The only bad results that are publicized are those which result in malpractice suits with large judgments against physicians.

IMJ: ***Is today's problem any different from the malpractice crisis of the mid-1970s?***

Dr. Hamilton: For perspective, let's go back even further than that. When I started practice as an orthopedic surgeon in 1962, my first malpractice premium was $51 a year. And that was coverage for $5,000 per incident and a total aggregate of $15,000 a year. Now, many physicians pay *double* that $51 *a day* for malpractice insurance, and that $5,000 wouldn't pay for more than a couple of depositions in a lawsuit.

Malpractice suits were unusual at that time. Only a few publicized cases even got to court. By the early '70s, the premiums started getting up to $500-700 a year. But then the number of suits increased so dramatically that by 1975, the commercial insurers who were insuring physicians of Illinois—as well as the Hartford which was the ISMS-sponsored group—wanted to get out of the market.

At this point, we were faced with a crisis of *availability* of malpractice insurance. ISMS met this availability crisis by starting the Illinois State Medical Inter-Insurance Exchange, so that we could provide malpractice insurance to our eligible member physicians at what we hoped would be a reasonable price.

Now we've found that, each year since we started the company, the incidence of suits and the severity of payments have spiraled nearly 20% a year. While the existence of the Exchange guarantees *availability* of coverage, premiums have increased to the point where we're now faced with a crisis of *affordability* of insurance.

A high risk specialist now carries a $32,000-35,000 a year bill in premiums, or nearly $100 a day. We are finding it difficult or impossible to pass this overhead cost on to the patients.

IMJ: *A hundred dollars a day is a lot of money. But is this something that's really a problem only with the high risk specialist?*

Dr. Hamilton: Oh no, it's a universal problem. There's no question that this affects the low-risk practitioner just as much as it does the high-risk specialist. A low-risk specialist can be sued for a million dollars just as easily as a high-risk person can.

Last spring, we sent a mail questionnaire to all our member physicians, asking their view of the professional liability situation. The survey underscored the importance that the members attach to these issues. Eighty percent of our respondents felt that malpractice was the most important problem facing them in medical practice today. The remainder ranked the problem as number two or number three.

So our members feel that malpractice is the most serious problem facing them. And it puts a big damper on what used to be a physician-patient relationship characterized by mutual trust. Now, patients are suspicious of physicians, and an increasing number of physicians look at patients coming into their office as potential litigants—people they may someday face in court.



IMJ: *How is the physician affected by this changing relationship?*

Dr. Hamilton: The physician is drawn into practicing defensive medicine. He orders the broadest possible range of tests rather than only those that are reasonably required to diagnose and treat a patient. But if the physician ends up in court, he'll need all of these extra test results to back him up.

The AMA estimates that $15.1 billion a year is spent on defensive medicine. It's further estimated that $725 million is spent in Illinois alone. This year, Illinois physicians will be paying over $200 million in premiums for malpractice insurance. Most, if not all of these costs, are passed on to the patient. But the most important thing to remember is that we are spending a tremendous amount of money that doesn't produce actual medical care value for the patient.

IMJ: *With respect to defensive medicine, cannot an argument be made that more tests are better? Don't they help you be a better diagnostician?*

Dr. Hamilton: It's true that more tests sometimes can pick up something that was not symptomatic at the time. But when we are talking about cost containment and trying to control the spiraling cost of medical care, we should be doing things that are cost effective. For example, the benefits of some formerly routine screening tests were found not to justify the cost of conducting the screening program.

IMJ: *What about the argument that the threat of a suit makes a physician practice better medicine?*

Dr. Hamilton: I don't believe that's necessary. I don't think that there's any physician practicing who does not want to meet the challenge of making a proper diagnosis and getting a patient well.

IMJ: *What is organized medicine doing to reduce a member's chances of being sued?*

Dr. Hamilton: Continuing medical education has been a concern not only of the state, county and national associations, but also of specialty societies. Physicians have always wanted to learn how to practice better medicine, and most societies offer continuing education programs. Some specialty societies require re-certification by examination. The Illinois Council on Continuing Medical Education is recognized as a national leader in continuing medical education.

As far as ISMS is concerned, we've been in the forefront in offering risk management programs in order to teach physicians about problems which can lead to malpractice suits—such as sloppy record keeping or lack of rapport with a patient.

I think the medical society also has been in the lead with respect to self policing. We're certainly behind the mandatory reporting amendments to the Medical Practice Act, where hospitals are required to report changes in privileges due to peer review decisions. Insurance companies are required to report every malpractice decision and settlement.

We've also acted to protect from attack the Medical Studies Act, which makes peer review activities

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undiscoverable and inadmissable in court. While there's been a lot of misunderstanding about this, the bottom line is that the Act protects physicians when reviewing their peers. Such protection encourages physicians to participate in the review process and makes for better medical care.

IMJ: *What about the legislative initiative ISMS has launched? What are you hoping to achieve in the Illinois General Assembly?*

Dr. Hamilton: Well, we're actually attacking two divisions of the malpractice problem. One is the incidence of suits and the other is the severity of a large amount of awards which are given out and settled.

I'd like to emphasize though, that in terms of the law, there are two things that are very, very important to us. First, we do not want to do anything that would deprive anyone of his or her day in court. That is a basic right. The second is, that if indeed malpractice has occurred, whether it's an accident or negligence, we want to see that patient compensated reasonably and fairly for the damage that has been done.

The incidence of claims and suits is something that we've seen go up, about 200%. Since we've had the Exchange, we have closed about 80% of our claims and suits without payment to the patients, which would indicate that most suits and claims filed against physicians are without merit. But even if a suit is totally spurious, it costs a lot of money to get the physician out of this mess.

One measure we're suggesting to address the incidence is the establishment of screening panels. These panels would consist of a physician, judge and attorney who would evaluate these cases and issue findings.

If either the physician or the patient disagreed with the panel, they could still go into court. However, if the panel decision were unanimous and they still went to court, they'd be responsible for court costs and attorney fees if they lost.



"We do not want to do anything that would deprive anyone of his or her day in court . . . if indeed malpractice has occurred, whether it's an accident or negligence, we want to see that patient compensated reasonably and fairly for the damage that has been done."

We also would like to make it easier for the physician to file a counter action against the patient and an attorney if the original suit was unjustified. Right now, any patient and attorney can bring a physician into court on the flimsiest pretext. But for a physician to bring that patient and attorney into court for malicious prosecution, the physician has to prove special damages—which is a nearly impossible task.

There hasn't been a successful counterclaim in the state of Illinois in the last 50 years. In 1978, however, a physician did countersue a patient and his attorney in circuit court. We saw the incidence of claims level off after this successful suit and actually decline over the two-year period while this ruling was in effect. But when the decision was reversed by a higher court, the suits started spiraling again just like they did before. So we know countersuits are effective.

We'd also like to see expert witnesses be more expert. We'd like to see a bigger portion of awards go to patients rather than their attorneys. And we're proposing that punitive damages be dropped.

We have to make awards a bit more reasonable. So we'd like to put a cap on non-economic losses for such things as pain and suffering, which are frequently inflated by sympathetic juries. Under our proposal, there would be absolutely no cap on actual losses. If the patient required millions of dollars for custodial care for the rest of his life or suffered economic losses or lost earnings, there would be no cap on that.

We also would like to see the payout of large awards made periodically rather than in a lump sum. That's a more economic way of doing it and would ensure that the patient who required a lifetime of care would have it. And we'd like to see damage awards reduced by the full amount of other insurance payments the patient might receive.

IMJ: *Are any of these proposals new or revolutionary?*

Dr. Hamilton: All of these were part of the package we introduced in the last legislative session. And I think it's important to note we did not just pull this package out of the air.

During the crisis of the mid 1970s, we proposed a legislative package. Other states have done the same. What we did in preparation for this initiative was to have experts study all the proposals and all the laws that have been passed in the United States regarding malpractice. We studied them and their effects on the problem. We also tried to have our bills written to be in consonance with the Illinois Constitution so that if they do pass they won't be struck down by the courts.

IMJ: *What happens if the ISMS legislation doesn't pass?*

Dr. Hamilton: The price of medical care simply will continue to have to go up to cover increasing premiums. The cost of insurance will have to be passed on to the consumer as

"People must realize that malpractice reform will have to be a significant part of any health care cost containment strategy."

individual patient or to his employer who is paying for health care coverage. People must realize that malpractice reform will have to be a significant part of any health care cost containment strategy.

I also think the old mutual trust in the physician-patient relationship



will continue to be eroded. Another thing we're seeing right now is that family physicians who were perfectly competent in higher risk procedures—such as minor surgery or delivering babies—are giving this up because they don't do enough to pay for that extra premium. We also are seeing older physicians who would like to practice part-time being forced to complete their retirement because of the costs of malpractice insurance. These situations may mean that patients will have to go further to get the same type of care they once received locally.

IMJ: *What will it take to push these proposals through the General Assembly?*

Dr. Hamilton: Legislators listen to the people who elect them. And we have been effective in the past with grass roots lobbying. For example, during a recent session of the legislature, there was a bill that would have assessed interest on malpractice awards retroactive from the date of judgment. Here in Cook County where it can be 5-7 years from the time of occurrence to the time of judgment, awards could easily double.

We asked our members to write their legislators, and we had a significant response. In fact, we had more than a thousand members and their patients and neighbors contact legislators. The result was that this bill was struck down in the Senate by a vote of 41 against and 14 for, and it wasn't even voted on in the House.

Once again physicians must contact their legislators, but the only way we can get malpractice reform through is for constituents to let their representatives and senators know that it's not just a concern of doctors. It's not a fight between doctors and lawyers. It is a problem for society itself. So that's why the participation of everybody is essential. If legislators hear only from physicians, they will feel it is just a physician's cause. But if they hear from a broad spectrum of their constituents, they'll realize it affects everybody. And they will be much more concerned about finding a solution.

IMJ: *How is the medical society going about developing support for its position?*

Dr. Hamilton: We currently are organizing "action teams" through county medical societies and individual hospital medical staffs. An action team is a group of physicians in a county or hospital who will serve as the leaders in communicating with the local media and civic clubs to get the word across that there is a problem. Action teams also will help physicians inform their patients.

And they'll communicate directly with legislators to convince them that we have some legislation that will help the situation. If necessary, they'll help coordinate physician visits to Springfield as part of an ISMS-sponsored rally.

IMJ: *What can the individual physician do today to help?*

"Legislators listen to the people who elect them . . . the only way we can get malpractice reform through is for constituents to let their representatives and senators know that it's not just a concern of doctors."

Dr. Hamilton: First, the physician should keep the best medical records he can. He can try to treat the patient with mutual trust and respect. He can continue to be the patient's advocate as physicians always have been. He can refuse to be a passive member of the community and become an active one—letting people know that physicians are trying to do as much as they can to contain the cost of medical care without decreasing the quality or introducing rationing. And he can make his opinions known to the people who represent him. ◀

1985 General Assembly Profile

The Initiative Heats Up

The Illinois General Assembly opened its 1985 legislative session on January ninth. It's expected that legislators will confront the issue of medical malpractice prior to the legislature's June 30 adjournment.

The Illinois State Medical Society's drive for malpractice reform is expected to be difficult. Intense opposition is expected from some trial attorneys anxious to preserve the status quo. In addition, malpractice reform is only one of several important issues (*e.g.*, funding for education, the 1992 World's Fair, toxic wastes and other environmental concerns) that will compete for legislators' time. Literally thousands of bills—pushed by hundreds of "special interest" groups—are expected to be introduced in the General Assembly. Each bill must be acted upon before June 30.

The composition of the General Assembly was not changed much by the November elections. Democrats retained a slim 2-vote majority in the 59-member Senate, while their margin is stronger in the House. Of the 118 representatives, 67 are Democrats.

In the House, Rep. Michael Madigan (D-Chicago) was re-elected speaker, and Rep. Lee Daniels (R-Elmhurst) was elected minority leader. An influential leader, Rep. Madigan has solidified his position in the House, in part through his work in the last legislative redistricting effort and his creation of a special campaign support committee for Democratic candidates for representative. That committee has raised and distributed hundreds of thousands of dollars to support the campaigns of representative candidates throughout Illinois.

The Senate president post again went to Sen. Philip Rock (D-Oak Park). During last year's session, Sen. Rock was the sponsor of a proposal that would have permitted the assessment of interest on malpractice damage awards retroactive to the date of the injury. The pre-judgment interest provision was soundly defeated as the result of an intense lobbying effort by physicians throughout Illinois. Copies of more than 1,000 individual letters from physicians to their legislators were received by ISMS during the battle over the pre-judgment interest issue.

Also of interest to physicians should be the resignation of two House members, Reps. Aaron Jaffe (D-Skokie) and Richard Brummer (D-Effingham). Both legislators resigned to assume judicial appointments. Rep. Jaffe was an ardent opponent of the ISMS-developed malpractice reform legislation. He had served as chairman of the House Judiciary I Committee, which had blocked passage of the ISMS bills during the previous legislative session. Rep. Brummer, who had stated his opposition to much of the ISMS package of bills, had been a member of the same committee.

Since defeat of its legislation last session, the Illinois State Medical Society has encouraged a vigorous effort by its members to push for passage of malpractice reform legislation. The Society has maintained that constant communication with legislators is the key to passage. The communications program is designed to convince legislators of the seriousness of the malpractice crisis. The Society will seek to impress upon them the fact that the crisis affects society as a whole, as its implications reach for beyond the concerns of physicians alone.

The mechanism employed by the Society for this effort is the "action team." Action teams of physicians and other concerned parties are being formed by medical staffs in Illinois hospitals and by county medical societies. These teams are being asked to arrange meetings with legislators to discuss the malpractice problem and to coordinate educational programs aimed at community and business leaders, local media representatives, individual patients, and others who believe in the need for malpractice reform.

Task Force Created

The Illinois General Assembly also should be receiving recommendations from a special task force on medical malpractice created by Illi-

nois Governor James R. Thompson.

The task force is scheduled to meet in open session every Thursday afternoon through March 21. It is chaired by Gov. Thompson's former chief of staff Arthur Quern.

In its organizational meeting January 3, the task force heard from John Washburn, director of the Illinois Department of Insurance, regarding the scope of the problem. Washburn reported that the situation has reached the point where insurance carriers are paying out an average of $1.64 in losses and expenses for every $1.00 they receive in premiums. The same loss ratio in 1978 was $1.05, according to Washburn.

Washburn cited several major factors leading to the current situation, including:

- The large number of claims and the long delay before those claims are ultimately settled;
- Rapid technological developments, which cause fluctuation in standards of care;
- The rapidly increasing size of awards (resulting in part from differing interpretations of such elements as pain and suffering); and
- The unwillingness of reinsurers to underwrite coverage for large damage awards.

Under a schedule announced by Quern at the first session, the task force was to begin by acquiring background information and conducting public hearings on the problem. Work on the actual recommendations to be presented to the Illinois General Assembly was to begin with the February 28 session, and a final report to be presented to the Governor by March 25. ◀

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How A Bill Becomes Law

Rite of Passage

Legislation to reform the handling of medical malpractice claims faces a series of procedural hurdles. Physicians interested in obtaining malpractice reform should be familiar with the legislative process. A solid understanding will enable them to act appropriately when each of the hurdles is confronted. Following is a simple description of how a bill becomes law in the Illinois General Assembly.

Although many groups, such as the Illinois State Medical Society, offer legislative proposals, only legislators themselves may introduce bills into the Illinois General Assembly. Bills may be introduced in either legislative house, but ultimately must have the approval of both chambers and the signature of the governor before becoming law in Illinois.

The process for consideration of bills in both the House of Representatives and Senate is essentially identical.

Once introduced, a bill is ordered printed, called for a "first reading" and referred to the appropriate committee for consideration. Committees are organized according to subject, and membership generally ranges from 8-20 members. As the majority party, Democrats make up a working majority of each committee. Democratic representatives also serve as chairmen of each committee.

Committee hearings are held on each bill to afford an opportunity for proponents and opponents to appear and testify. After deliberation, the committee may either give a bill a "do pass," recommendation or may amend the bill and recommend it "do pass as amended." A simple majority of the committee members who are present for the vote is enough for the bill to pass from committee in the Senate. Rules of the House require a majority of all members appointed to the committee to approve the bill.

In some cases, a committee may adopt a "do not pass" motion that prevents the bill from continuing. Although failing to obtain enough votes on a "do pass" and obtaining a majority on a "do not pass" would appear to have the same result, the distinction is important. Bills which have received a "do not pass" vote are more difficult to resurrect later in the legislative process.

Committee votes to hold bills in committee may be overturned by a "motion to discharge" the committee. ISMS-sponsored malpractice bills may be involved in such votes since favorable action by the lawyer-dominated judiciary committees in the House and Senate will be difficult to obtain.

A successful motion to discharge a committee does not, however, mean a bill is approved. It merely passes the bill on to the next stage in the process. To be successful, discharge motions need a simple majority of the full chamber for approval, unless the committee action was a "do not pass" motion. A 3/5 majority of all members of the respective chamber is needed to overturn "do not pass" motions.

The Second Reading

After a committee has approved a bill, it is considered by the full chamber on "second reading." The second reading is for the purpose of adding amendments. Any member of the chamber may offer amendments to a bill. Amendments will be added if they receive approval of a simple majority of those voting on the question. Once all amendments have been considered, the bill is held for a third and final reading. Third reading is the final passage stage. A roll call vote is required, and a majority of the entire chamber must vote affirmatively for a bill to pass. Noncontroversial bills are sometimes placed on a "consent calendar" in which a number of bills are voted upon at one time to help speed the legislative process.

After a bill is approved on third reading in one chamber, it is sent to the other chamber to begin the process anew. Bills approved by the House of Representatives now will be assigned to Senate committees for consideration, and House committees will begin deliberations on Senate bills. If a bill survives its journey through the other chamber unchanged, it will be sent to the governor for his signature. If, however, new amendments are added or language is deleted, the bill must be sent back to its originating cham-

ber for concurrence.

For example, if the Senate amends a House bill, the bill will be presented to the full House for a vote to concur. Further committee action will not be necessary. If the House refuses to concur, the Senate will be asked to retreat from its stance and approve the bill in the original House form. If the Senate stands fast on its amendment, a "conference committee" will be convened to consider the two versions together and work out a compromise version. Conference committees usually are comprised of five members of each house appointed by the party leadership.

Conference committees are relatively unrestrained in what they may do with the bills at hand. Completely new language can be offered during conference committee deliberations. Once drafted, conference committee reports must be approved by both chambers. The conference committee may have one additional opportunity to submit a different version of its report if its original report is rejected.

A Third Hurdle

A bill approved by both chambers must go to the governor within 30 days of its passage. The governor has several options. He may sign the bill into law. He may send it back to the legislature for recommended changes (called an amendatory veto). If it is a bill appropriating state funds, the governor may veto or reduce a particular appropriation within the bill. Or, the governor may veto an entire bill. If the governor takes no action within 60 days of receiving a bill, it becomes law without his signature.

If the governor vetoes a bill, the legislature may override the veto by a vote of 3/5 of the members elected to each chamber. The legislature can restore a reduction of an appropriation item by a simple majority of each chamber. A simple majority is all that is needed to restore amendatory vetoes.

The Final Test

Gubernatorial approval is not necessarily the final step in a new law's enactment. Court challenges may be entered as to a law's constitutionality, and the law may have to withstand many such challenges. Several malpractice reforms passed by the legislature in 1975 were ruled unconstitutional by the Illinois Supreme Court, and opponents of physician-backed legislation can be expected to pursue similar challenges if the General Assembly makes significant changes in the legal system for handling malpractice claims. ◀

Illinois State Medical Society

Illinois State Medical Society Auxiliary

Second Annual Benefit Raffle

for the

Educational and Scientific Foundation's

Medical Student Loan Fund

Drawing Held April 26, 1985

At ISMS Annual Meeting

Grand Prize: Trip for Two to an Exotic Location

Other prizes to be announced

Ticket books mailed to all
ISMS/ISMSA members

$6.00 per ticket

$50.00 per 10-ticket book
Winners need not be present

Contributions to the ISMS Educational and Scientific Foundation are normally tax deductible to the extent allowed by law.

Communicate
Together We Can Make A Difference

A Tribute to Life

By Vivian Reardon, ISMSA president, and
Cathy Monahan, president, Auxiliary of the Lake County Medical Society

Throughout Illinois, county medical society auxiliaries form coalitions with other community organizations in order to facilitate the operation of medically related projects. These collaborations provide greater manpower and a broader base of awareness. One such activity recently undertaken by a county auxiliary has some unique aspects.

The auxiliary of the Lake County Medical Society was seeking a public service project. Guidelines dictated that it be a project that would unite the medical community, provide a service, enhance public relations of the auxiliary, be inexpensive and require few people to execute.

The idea for their undertaking was born when the Lake County president read Dr. Michael O'Donnell's publication of Sir Cyril Clarke's proposal for the establishment of living memorials for organ donors. Appearing in the *British Medical Journal* of January 7, 1984, the article stated, "Doctors who have had to deal with parents of adolescents or young adults who have been killed in accidents . . . will accept Sir Cyril's proposition that, immediately after the accident, a dominant feature of parental grief is a feeling of a young life wasted, of potential unrealized. He suggests that if the death, and the chance of life it (organ donation) offered to another person were commemorated in some lasting way—say by the planting of a tree or some similar memorial—the very act of commemoration would do much to assuage a major element of the parents' grief."

Inspired by this thought, the auxiliary embarked on establishment of a program to plant a tree as a living memorial to commemorate each organ donor. It was hoped that this would recognize organ donation while helping to ameliorate the grief of the donor's survivors.

Following approval of the county medical society and encouragement by local transplant teams, the seven local hospitals were approached concerning the plan. The hospitals were enthusiastic. Since the program was to be ongoing with no expense, trees had to be located. One local nursery agreed to donate sizable trees. The hospitals accepted the responsibility of picking up, planting and caring for the trees.

Publicity launching the project was arranged with a photo session at the donating nursery followed by press releases sent to all local papers.

Lake County covers 460 square miles and has a diverse population of over 400,000. Therefore, in order to reach a greater segment of the population, each hospital agreed to develop its own public relations program involving the tree planting project. Stipulation was made that the donating nursery and the auxiliary of the Lake County Medical Society be mentioned.

Each of the seven area hospitals is also to erect a plaque to commemorate the donors from that hospital. It is intended that these memorials will acknowledge the donor's contribution to the life of another person. By being in the public eye, it is hoped that the memorials will help the relatives and the physicians of the dying to feel that they are permitting their loved one or patient to make a meaningful contribution to the life of another.

This auxiliary-initiated project has been enthusiastically received in the community and has since inspired inquiry from beyond the borders of Lake County. ◀

Society of Critical Care Medicine Presents its 14th Annual Symposium



Hyatt Regency Chicago May 21-25, 1985

CONTINUING EDUCATION UNITS have been approved by the Council for Continuing Medical Education (ACCME) Category I.
CCM SUBSPECIALITY EXAM Critical Care Self Assessment Program VI (CCSAP VI) will be given on Tuesday, May 21. Discussion of the results, answers and rationales will be given on saturday, May 25.
DISCOUNT AIRFARES of 40-45% available through AIR TRAVEL SERVICE; call toll-free at (800) 241-5644.
SPOUSES TOURS of Chicago's highlights will be offered by CHICAGO IS . . . INC.
VOLUME 6 of CRITICAL CARE STATE OF THE ART will be the syllabus for plenary lectures.

REGISTRATION FORM

YES, I WANT TO ATTEND THIS IMPORTANT MEETING

REGISTRATION FEE INCLUDES TEXTBOOK, SPECIAL EVENING FUNCTIONS (Not applicable to daily registrants)

SCCM MEMBERS	MAIL REGISTRATION	ON-SITE	DAILY** (ON-SITE ONLY)
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Nurses, Allied Health Personnel Associate Members	$225	$275	$60
NON MEMBERS			
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Intern*, Residents,* Fellows*, Nurses, and Allied Health Personnel	$270	$320	$70
Full-time Student*	$100	$100	$25

*Requires verification letter
**Registrants on a daily basis do not receive a textbook

DAILY REGISTRATION ON-SITE ONLY

REFUND REQUEST MUST BE MADE IN WRITING
Up to April 30, 1985—full refund less $50 processing fee.
Up to May 10, 1985—50% refund.
Mail registration must be received by May 10, 1985

NO REFUND AFTER MAY 10, 1985

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Spouse's name _____

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Fullerton, CA 92635

Symposium registration $ _____
Spouse registration $ _____
Total fees enclosed $ _____

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IMJ

PRELIMINARY CONTENT

PLENARY LECTURERS

Economic Issues; Critical Care Medicine in the 80's
Jeffrey A. Augenstein, MD, PhD
Pre-Operative Pulmonary Function Testing
Philip G. Boysen, MD
The Ventilator Dependent Patient: Medical & Social Care
Robert G. Kettrick, MD
Positive Airway Pressure: System Design & Clinical Application
Robert R. Kirby, MD
Treatment of Acute Myocardial Infarction, 1985
Charles Rackley, MD
Brain Resuscitation: 'Fact or Fancy'
Harvey M. Shapiro, MD
Transplantation
Thomas E. Starzl, MD, PhD
Management of Pain & Pain Related Problems in the Critically Ill Patient
Theodore H. Stanley, MD
Hypertensive Crisis in Critical Care
W. Leigh Thompson, PhD, MD
Trauma Critical Care Units: What Price Salvage?
Alexander Walt, MD

HEMODYNAMIC MONITORING WORKSHOP

PANELS

Critical Care Medicine and Nursing — Practice, Problems and Solutions
Frank H Gafford, IV. MD, Chairman
Management of Critically Ill - Immunocompromised Patients
Joseph E. Parrillo, MD, Co-Chairman
Henry Masur, MD, Co-Chairman
Uniformed Services Scientific Section
Robert W. Taylor, MD, Head of Section
Cellular Mechanism of Acute Lung Injury: A Basis for Future Therapy for ARDS
Jean E. Rinaldo, MD, Chairman
Industry: a) Impact of DRG's on . . .W. Leigh Thompson, PhD, MD
b) Impact of Product Liability on . . . David Swedlow, MD
Judy Snyderman, MBA, Chairman
Does an Ounce of the Right Pre-Hospital Care Save a Ton of ICU Care — Which Interventions Really Make a Difference?
Paul E. Pepe, MD, Chairman
Critical Care Research – Asking the Right Question
Joseph M. Civetta, MD, Chairman
Critical Care Research – How to Answer the Question
Bart Chernow, MD, Chairman
Surgical Seminar on Newer Diagnostics and Therapeutic Modalities in Acute Lung Injury
Harvey J. Sugerman, MD, Chairman
Positive Pressure Breathing Systems – Differences Do Exist!
Robert R. Kirby, MD, Chairman
Chronic Respiratory Failure in Infants and Children: A Medical/Societal Dilemma
Robert G. Kettrick, MD, Chairman

PHYSICIAN SPECIALISTS

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Family Practice	Pediatric Cardiology
General Surgery	Pediatric Surgery
Infectious Disease	Psychiatry
Internal Medicine	Radiology
Neurology	Radiotherapist

FOR MORE INFORMATION CALL OR WRITE:

Captain Brian Legg
111 N. Wabash Ave.
Garland Building Suite 1805
Chicago, IL 60602
263-1207/1208
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PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602.

BLOOMINGTON:
Internal Medicine—To join an active six member IM practice in mid-western university community. A sub-specialty in Rheumatology, Endocrinology, or Allergy is desirable, but not necessary. Contact: J. Buchanan, The Health Center, 702 N. East St., Bloomington 61701 (309-827-5051). (2)

FRANKFORT:
Multi-specialty group thirty miles southwest of Chicago seeks board elegible obstetrician-gynecologist to join expanding practice. Incentive plan, profit-sharing, relatively new building. Excellent practice opportunity with above average grade and high schools. Contact Howard Osmus, Administrator, Hedges Clinic, Frankfort, Il. 60423. (815-469-2123) (2)

KANE COUNTY:
Experienced occupational health physician needed to direct medical program in manufacturing plant in Southwest Suburbs. Call regional medical director (312)981-2195. (4)

ROCK ISLAND:
Internist group looking for a fourth physician to join growing area of Illinois Quad Cities. General internist and/or internist with sub-specialty willing to practice some general internal medicine. Offering financial guarantees and free rent for first year. Contact: Greg Romans, 2701 17th Street, Rock Island, IL 61201. (3)

SAYBROOK
Family practitioner—Excellent opportunity in east central Illinois; large modern office available; rural setting near modern well equipped community hospital; community is within twenty minutes of major universities, tertiary care centers; metropolitan area with major shopping, recreational and cultural activities available; financial incentives possible. Contact William Stack (309) 475-3521. (3)

VANDALIA
Specialists wanted. Family practice, internal medicine, pediatrics, general surgery, ENT, orthopedic surgery. One year guarantee with free office space. Needed for 92 bed acute, 134 bed LTC hospital in southern Illinois. Market covers 25,000+ people. Single office or clinic setting possible. Contact: Darrell Pile, Adm., Fayette Co. Hospital, Taylor Street., Vandalia, 62471 (618) 283-1231. (3)

MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Ten patients from the VA Medical Center at Salt Lake City with diagnoses of CVA at the middle cerebral artery were evaluated by electrophysiologic tests and reaction time to elicit functional impairments beyond the areas of pathology. The authors concluded that CVA reduced the electrophysiologic concordance between brain regions as reflected in EEG coupling and visual evoked potential intercorrelation procedures. The disruption was more severe if the CVA affected the right as opposed to the left middle cerebral artery. (Gummow, L., *et al., Electroencephalography and Clinical Neurophysiology* 58#5:400-7, 1984)

A retrospective analysis of palmar keratoses revealed that 87% of patients with bladder cancer and 71% of cases with lung cancer had palmar keratoses contrasted to an incidence of palmar keratoses in 36% of the control population. The prevalence increased with age and was more common in males but the type of keratoses appeared similar in all cases. (Cuzick, J., *et al., Lancet* 1:530, 1984)

Zinc supplementation has been found beneficial to growth and body weight in 14-18 year old patients with sickle cell anemia. Spectrophotometry of zinc in neutrophils correlated with height, weight and serum testosterone levels but not in plasma or erythrocytes. The neutrophil zinc level is thus suggested as a reliable and sensitive indicator of deficiency in sickle cell disease. (Prasad, A., *et al.: Ann Intern Med.* 100:367-71, 1984)

A randomized, placebo-controlled, double blind study on the efficacy of nicotine chewing gum revealed a 29% abstinence from cigarettes as contrasted to a 16% abstinence in the placebo gum cases. The nicotine gum group had less craving and experienced few and non-serious side-effects. (Hjalmarson, A.: *JAMA* 252#20:2835-8, 1984)

Traumatic diaphragmatic herniation is reported in approximately 4.5% of cases from blunt or penetrating trauma to the abdomen, more often in the left side. Tears of the diaphragm may be missed on the right because of the liver imitating an elevated diaphragm. The presence of the stomach in the thorax is easily demonstrated on x-ray by passage of a nasogastric tube. Missed cases may present with late onset of vague gastrointestinal symptoms of nausea, anorexia, chest pain, dyspnea, shoulder pain, or recurrent episodes of pneumonia. Closure surgically of the herniation is suggested early because delayed repair may elicit diaphragmatic atrophy. (Fajolu, O.J.: *Nat. Med. Ass.* 76#12:1163-4, 1984)

The outcome of delayed pregnancy among women over 30 was analyzed and compared to those younger. The risk of late fetal deaths was greatest in those aged 35-39. Low birthweight and pre-term deliveries increased in incidence with the age of the mother. (Forman, M., *et al, JAMA* 252#22, 3135-9, 1984)

The hepato-jugular reflux was evaluated in 15 cases each with previously diagnosed tricuspid regurgitation, with mitral regurgitation, and a control group. The examiner exerted firm upward pressure below the right costal margin and evaluated the resultant murmurs and a phonocardiograph. Positive results were obtained in 100% of group one and 66% of group two. The hepato-jugular reflux is thus suggested as a useful adjunct in the diagnosis of tricuspid regurgitation. (Maisel, A., *et al: Ann Intern Med.* 101#6:781-2, 1984)

The blood pressure, degree of smoking, serum cholesterol, and fibrinogen level measured at the base line were found to be significant for infarction in a 13.5 year follow-up. Fibrinogen and smoking were strongly related to each other. Blood pressure and fibrinogen were risk factors for stroke and remained so irrespective of smoking and serum cholesterol. (Wilhelmsen, L., *et al: N Engl J Med* 311#8:501-5, 1984)

Anticoagulant therapy should be delayed for at least three days in patients with a cerebral embolus secondary to rheumatic heart disease. In 42 cases studied, hemorrhagic infarcts occurred in seven cases and five of these occurred within 48 hours. Hemorrhagic infarcts may be a frequent cause of recurrent strokes after a cerebral embolus and its outcome may be worsened by the early use of anticoagulants. (Calandre, L., *et al: Arch Neurol* 41:1152-4, 1984)

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

MARCH

General Medicine

Medical Seminar-at-Sea
For: Physicians, Surgeons. Caribbean Cruise, March 3-11, 1985. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, Illinois 62708. **Fee:** $400.00. **Reg. Limit:** None. **Credit:** Category 1, 36 hours; AAFP, 36 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711.

Medicine

Infectious Disease Symposium
For: Physicians, Surgeons, Staff. Symposium, March 29, 1985, 1:00-5:20p.m., Pinckneyville, Illinois. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, Illinois 62708. **Fee:** $45.00. **Reg. Limit:** None. **Credit:** Category 1, 4 hours; AAFP, 4 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** 217-782-7711.

Inflammatory Bowel Disease
For: Physicians. Symposium, March 29, 1985, St. Louis, Missouri. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, Missouri. **Fee:** $100.00. **Reg. Limit:** 175. **Credit:** AAFP, 6 hrs; AMA Category 1, 6 hrs; AOA, 6 hrs. **Contact:** Loretta Giacoletto. **Phone:** (800)325-9862

Management of Childhood and Adolescent Skin Diseases
For: General Practitioners, Pediatricians. Lecture, March 18-20, 1985, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago. **Fee:** $380.00 **Reg. Limit:** 90. **Credit:** Category 1, 20 hrs. **Contact:** Robert J. Baker. **Phone:** (800)621-4649 in Illinois, (800)621-4651 outside Illinois

Ophthalmology

Ophthalmology Current Concepts Seminar '85
For: Ophthalmologists. Lectures, workshops, exhibits March 28-29, 1985 and optional March 30, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg, 610 Walnut Street, Madison, Wisconsin 53705. **Cosponsor:** University of Wisconsin-Madison, School of Medicine, Department of Ophthalmology. **Fee:** TBD. **Reg. Limit:** None. **Credit:** Category 1, TBD; UW-Extension CEU's, TBD. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** 608-263-2856.

Psychiatry

Comprehensive Psychiatry Review Part II: The Psychiatric Interview
For: Psychiatrists. Course, March 8-10, 1985, Chicago, Illinois. **Sponsor:** The University of Chicago, 5841 South Maryland, Box 139, Chicago, Illinois 60637. **Fee:** $375.00. **Reg. Limit:** None. **Credit:** Category 1, 17 hours. **Contact:** Mary Ann Dillon. **Phone** 312-962-1056.

Comprehensive Psychiatry Review Part I: Basic Considerations
Psychiatrists. Course, March 17-23, 1985, Chicago, Illinois. **Sponsor:** The University of Chicago, 5841 South Maryland, Box 139, Chicago, Illinois 60637. **Fee:** $500.00. **Reg. Limit:** None. **Credit:** Category 1, 42 hrs. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056

The Clinical Basis of Psychiatry
For: Psychiatrists & Neurologists. Lecture, Francois E. Alouf, M.D., (Coordinator), March 4-8, 1985, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Fee:** $590. **Reg. Limit:** Maximum 90. **Credit:** Category 1, 45 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Allergy

Lectures, March 1-3, 1985, Chicago, Illinois. **Sponsor:** Joint meeting with Chicago Medical Society, Midwest Clinical Conference. **For:** Allergists.

Pathology

Preleukemias and Myeloid Dysplastic Syndromes
For: Pathologists, Hematologists. Lecture, March 18, 1985, 7:00 PM., Drake Hotel, Chicago, Illinois. **Sponsor:** Chicago Pathology Society & Institute of Medicine of Chicago. **Co-sponsor:** Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hrs. **Contact:** Marshall H. Short. **Phone:** 312-626-4300 Ext. 5720.

Medicine

Pain—Mechanisms, Assessment and Management
For: MDs. Conference, March 22, 23, 1985, Chicago. **Sponsor:** Illinois Physical Medicine Society, V.A. Hines Hospital. **Fee:** $80.00. **Registration deadline:** March 12, 1985. **Credit:** 11.5 hours, Category 1 (applied for). **Contact:** Jay Subbarao, M.D. **Phone:** (312) 343-7200 x2282.

30 Specialties

Midwest Clinical Conference
For: M.D.'s, D.O.'s, residents and medical students. Lectures, March 1-3, 1985, 8:30 to 5 daily, Westin Hotel, Chicago, Illinois. **Sponsor:** Chicago Medical Society, 515 N. Dearborn St., Chicago, IL 60610. **Fee:** $100 for non-CMS member or non-participating specialty society. **Reg. Limit:** None. **Credit:** Category 1, 20 hours. **Phone:** 670-2550 ext. 238.

Surgery

Industrial Injuries to the Hand
For: Physicians. Symposium, March 9, 1985, St. Louis Missouri. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, Missouri 63110. **Fee:** $100.00 **Reg. Limit:** 150. **Credit:** AAFP Prescribed, 6 hrs; AMA Category 1, 6 hrs; AOA, 6 hrs. **Contact:** Loretta Giacoletto. **Phone:** (800)325-9862.

Peripheral Vascular Disorders
For: Physicians. Symposium. March 15-16, 1985, St. Louis, Missouri. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, Missouri 63110. **Fee:** $150.00. **Reg. Limit:** 150. **Contact:** Loretta Giacoletto. **Phone:** (800)325-9862

Industrial Rehabilitation

Industrial Rehabilitation Issues: A Symposium
For: Industrial phys, emergency phys, rehab specs., employers, insurance adjusters, reps, lawyers. Symposium, March 7, 1985, 9:00 a.m.-4:00 p.m., Champaign, Illinois. **Sponsor:** Carle Foundation Hospital, Educational Services, Carle Foundation Hospital, 611 West Park Street, Urbana, IL 61801. **Cosponsor:** University of Illinois College of Medicine at Urbana-Champaign. **Reg. Deadline:** March 1, 1985. **Fee:** $75-$100. **Reg. Limit:** None. **Credit:** Category 1, 6.0 hours; AAFP Prescribed, 6.0 hours (applied); American College of Emergency Physicians Category 1 credit (applied for) 6 hours. **Contact:** Robert May. **Phone:** 217/337-3144.

Flexible Sigmoidoscopy

Flexible Sigmoidoscopy
Practicum session, March 22-23, 1985, The Arizona Biltmore Resort, Phoenix, Arizona. **Sponsor:** The Section on Gastroenterology of St. Luke's Medical Center, Phoenix. **Co-sponsor:** The Arizona Society of Gastrointestinal Endoscopy. **Contact:** Christine Campbell, Director, Department of Medical Meetings. **Phone:** (602) 251-8402.

APRIL

Allergy

Gastroesophageal Reflux
For: Allergists. Lecture, April 22, 1985, 8:00 PM, Holiday Inn Chicago City Centre. **Sponsor:** Illinois Society of Allergy & Clinical Immunology, 800 E. Northwest Highway, #101, Mount Prospect, Illinois 60056. **Fee:** $15.00 dinner. **Reg. Limit:** None. **Credit:** Category 1, 1 hour. **Contact:** Dianne K. Kubis. **Phone:** 312-255-1024.

General Medicine

Care of the Aging Patient
For: Physicians. Symposium, April 11-12, 1985, St. Louis,

Missouri. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, Missouri 63110. **Fee:** $200.00. **Reg. Limit:** 150. **Credit:** AAFP prescribed, 13.5 hours; AMA Category 1, 13.5 hours; AOA, 13.5 hours. **Contact:** Loretta Giacoletto. **Phone:** (800)325-9862.

Eighth Annual Sports Medicine Symposium
For: Physicians, Nurses, Therapists. Symposium, Lectures, April 12-13, 1985, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, 465b WARF Bldg., 610 Walnut Street, Madison, Wisconsin 53705. **Fee:** TBD. **Reg. Limit:** None. **Credit:** Category 1, TBD hours; AAFP prescribed, TBD hours; AOA, TBD hours. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856. **Co-sponsor:** American College of Sports Medicine, University of Wisconsin Hospital.

Infectious Diseases

Infectious Disease Update—1985
For: Physicians, Nurses. Conference, April 18-19, 1985, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut Street, Madison, Wisconsin 53705. **Co-sponsor:** University of Wisconsin School of Medicine, Department of Medicine, Section of Infectious Diseases; University of Wisconsin Hospital. **Fee:** TBD. **Credit:** Category 1, TBD hours; AAFP prescribed, TBD hours; AOA, TBD hours. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Obstetrics-Gynecology

Electronic Fetal Monitoring Workshop
For: Ob-Gyn's. Workshop, April 13, 1985, 8:30-5:00, Chicago, Illinois. **Fee:** $135 (Fellows, Jr. Fellows of ACOG) $150 (others); $68 (Life Fellows, Jr. Fellow Residents). **Credit:** Category 1, 7 hours; ACOG Program for Continuing Professional Development, 7 hours. **Sponsor:** American College of Obstetricians and Gynecologists, 600 Maryland Avenue, S.W., Suite 300 East, Washington, DC 20024. **Contact:** Robin Murray. **Phone:** 202-638-5577 Ext. 343.

12th Annual Obstetrics and Gynecology Symposium
For: Physicians. Symposium, April 25-26, 1985, St. Louis, Missouri. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, Missouri 63110. **Fee:** $200.00. **Reg. Limit:** 150. **Credit:** AAFP prescribed, 12 hours; AMA category 1, 12 hours; AOA, 12 hours. **Contact:** Loretta Giacoletto. **Phone:** (800)325-9862.

Management of Complications of Gynecologic Surgery & Urology
For: Gynecologists, Urologists. Course, April 26-27, 1985, Chicago, Illinois. **Fee:** $225.00. **Credit:** AMA Category 1, 10 hours; ACOG, 10 hours. **Sponsor:** The University of Chicago, 5841 Maryland Avenue, Box 139, Chicago, Illinois 60637. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056.

Pathology

Clinical Toxicology in the Hospital and in the Medical Examiners Office
For: Pathologist. Lecture, April 8, 1985, 7:00 PM, Drake Hotel, Chicago, Illinois. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hours. **Sponsor:** Chicago Pathology Society, Loretto Hospital, 645 S. Central Avenue, Chicago, Illinois 60644-9987. **Co-sponsor:** Michael Reese Hospital and Medical Center. **Contact:** Marshall H. Short, MD. **Phone:** 312-626-4300 Ext. 5720.

Cardiac Rehabilitation

8th Cardiac Rehabilitation Symposium: Exercise & Heart Disease, Prevention and Rehabilitation, 1985
For: All health professionals. Symposium with workshops, April 30-May 3, 1985, Milwaukee, Wisconsin. **Fee:** $385 (physicians), $170 (others). **Reg. Limit:** None. **Credit:** Category 1, to 24 hours, Other, University of Wisconsin-Extension CEUs, to 24 hours. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg.; 610 Walnut St., Madison, Wisconsin 53705. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** 608/263-2856.

Medicine

Musculoskeletal Problems Associated With Sports Injuries
For: MDs. Conference, April 20, 1985, North Chicago. **Sponsor:** Department of Rehabilitation Medicine, The Chicago Medical School with the Roloke Co. **Credit:** 8 hours, Category 1. **Contact:** Eugene J. Rogers, M.D., F.A.C.P., Professor and Chairman, Department of Rehabilitation Medicine, Chicago Medical School, 3333 Green Bay Road, North Chicago, Illinois 60064. **Phone:** (312) 578-3000.

Unique Seminars

The "Leadership" seminar assists the medical leadership in understanding the basic elements of effective CME planning. Participants will gain a foundation of skill in group techniques to involve medical staff members in CME planning and in how to start the systematic effort that leads to effective CME in the hospital setting.

The "Evaluation of CME Process" seminar provides the medical leadership with the practical information to apply the purposes of evaluation to program administration, faculty performance and participant learning. The leadership will discuss various common techniques used in the evaluation process for the development and implementation of quality CME programs.

For further information about participating in a unique ICCME seminar, please contact the Illinois State Medical Society, Twenty North Michigan Avenue, Chicago Illinois 60602 (312-782-1654).

MAY

Surgery

Hair Replacement Surgery
For: Surgeons. May 15-19, 1985. **Sponsor:** Northwestern University Medical School. **Fee:** $675.00. **Contact:** J.B. Pinski, M.D., 55 East Washington Street, Chicago, Illinois, Suite 3404 for more information.

Cardiology

Coronary Artery Disease and Sudden Death; Primary and Secondary Prevention.
For: Primary Care Audience. Workshop/Lecture, May 3-5, 1985. Chicago—Hyatt Woodfield Hotel. **Sponsor:** International Medical Education Corporation, 64 Inverness Drive East, Englewood, Colorado 80112. **Fee:** $295.00. **Limit:** 75. **Credit:** Category 1: 13 hours; AAFP Prescribed: 13 hours; AOA: 13 hours. **Contact:** Beverly Jacobsen. **Phone:** 800/525-8651, extension 273.

Diagnosis and Treatment of Thromboembolic Disease, 1985 Conference, May 16, 17, 18.
For: Physicians in patient care. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Building, 610 Walnut Street, Madison, Wisconsin 53705. **Fee:** N/A **Limit:** None. **Credit:** CEU's: 10 hours, Category 1: 10 Hours. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** 608/263-2856.

Critical Care Medicine

14th Annual SCCM Educational and Scientific Symposium May 21-25, 1985
For: Critical Care Physicians, Nurses, Therapists and Scientists. **Sponsor:** Society of Critical Care Medicine, 223 East Imperial Highway, Suite 110, Fullerton, California 92635. **Fee:** Non-Member Physicians $375; Nurses and Therapists $270; Member Physicians $275; Member Nurses and Therapists $225. **Limit:** None. **Credit:** Category 1 up to 40 hours. **Contact:** Tracy Schultz, **Phone:** 714/870-5243.

Allergy

Dermatology and Allergy Symposium.
For: Physicians, Surgeons, Staff. Symposium, May 15, 1985, 1:00-5:20 p.m. Nashville, Illinois. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, Illinois 62708. **Fee:** $45.00. **Credit:** Category 1:4 hours, AAFP Prescribed: 4 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** 217/236-7711.

Annual Alan Feinberg Resident-Fellow Program, May 20, 1985, 8:00 p.m.
For: Primarily Allergists. Lectures, Holiday Inn Chicago City Centre. **Sponsor:** Illinois Society of Allergy and Clinical Immunology, 800 East Northwest Highway #101, Mount Prospect, Illinois 60056. **Fee:** $15.00 dinner. **Limit:** None. **Credit:** Category 1, 1 hour. **Contact:** Dianne K. Kubis. **Phone:** 312/255-1024.

Cardiovascular

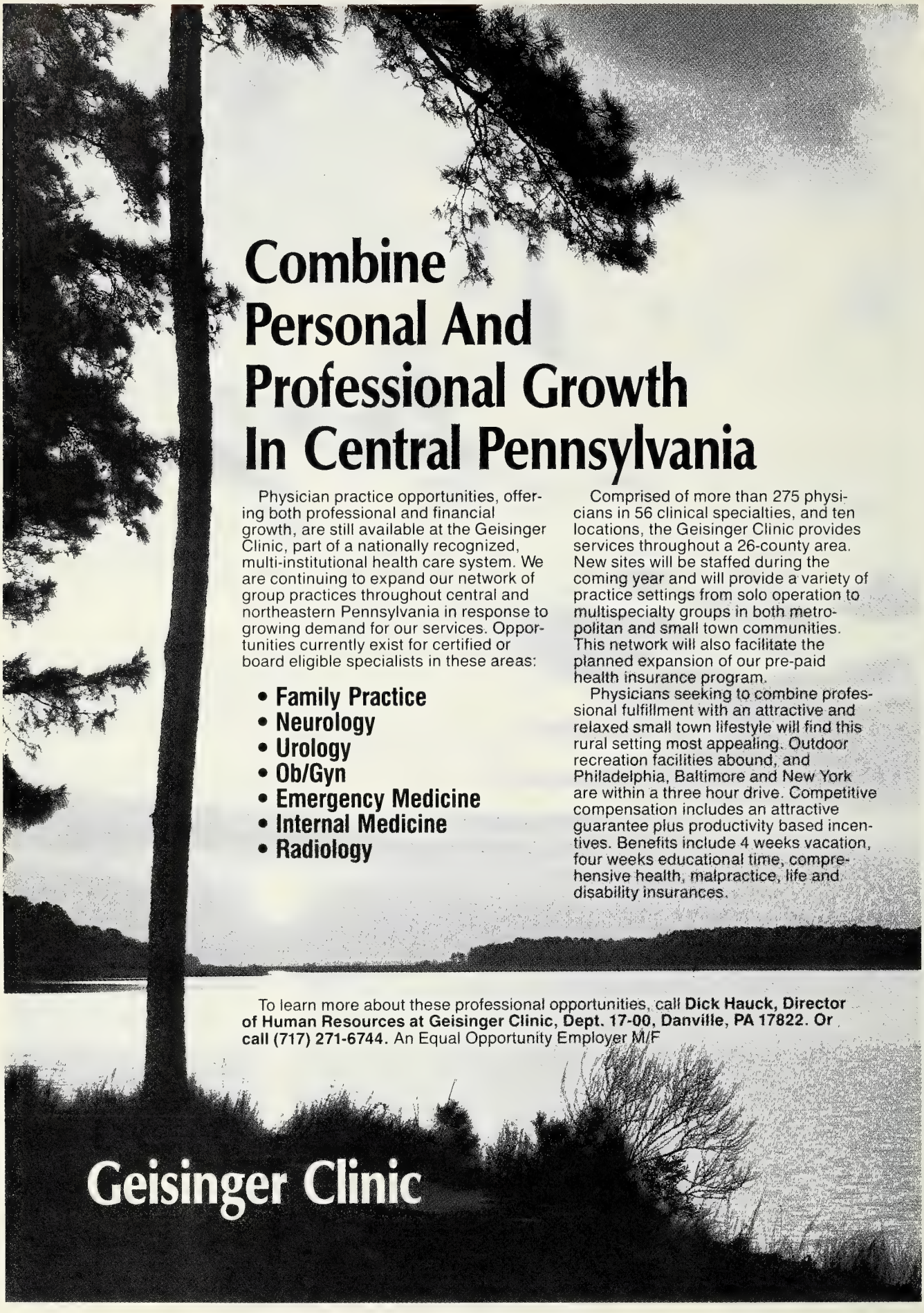
Second Biennial Chicago Cardiovascular Symposium.
For: All Physicians. Course, May 8-10, 1985. Chicago, Illinois. **Sponsor:** American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104. **Fee:** N/A **Limit:** N/A **Credit:** Category 1: 15 hours. **Contact:** Maxine Topping, Section Chief. **Phone:** 215/243-1200.

Pathology

Modern Methods of Diagnosis in Tumor Pathology, Slide Seminar.
For: Pathologists. May 13, 1985, 7:00 p.m. Drake Hotel, Chicago, Illinois. **Sponsor:** Chicago Pathology Society. **Fee:** For dinner. **Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall H. Short, M.D., Loretto Hospital, 645 South Central Avenue, Chicago, Illinois.

Psychiatry

Comprehensive Psychiatry Review Part II: The Psychiatric Interview.
For: Psychiatrists. Course, May 17-19, 1985. Chicago, Illinois. **Sponsor:** The University of Chicago, 5841 South Maryland, Box 139, Chicago, Illinois 60637. **Fee:** $375.00. **Limit:** None. **Credit:** Category 1: 17 hours. **Contact:** Mary Ann Dillon. **Phone:** 312/962-1056.



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Another Professional Responsibility



We Illinois physicians can be proud of the way we keep our house in order, despite recent charges to the contrary.

Bad physicians and impaired physicians, unfortunately, have always existed, and we acknowledge the fact.

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Physicians suspecting that a colleague may suffer from mental, physical or addiction problems too often assume that he or she can handle such a problem alone. They hesitate to bring an obvious impairment problem to a colleague's attention. That failure to act can, in effect, enable the sick physician to continue progressing toward the inevitable destruction of his or her personal and professional life.

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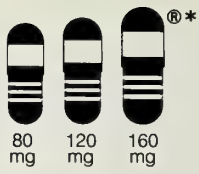


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INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the platelets of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

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Anxiety Relief for the Patient Who Must Remain Alert[1-8]



Tranxene dramatically increased beta wave activity

- relieved anxiety
- maintained alertness

In a double-blind randomized study of 20 patients with generalized anxiety disorder, patients treated with Tranxene showed marked improvement in Hamilton Anxiety Ratings, and dramatic increase in beta wave activity.[1] Beta wave activity is associated with concentration, attention, mental focusing.[1,9,10]

...plus Tranxene offers a time-proven profile of safety

The Tranxene safety record is backed by over 12 years of clinical success. There's little likelihood of problem sedation* with Tranxene, and adverse reactions such as withdrawal seizures and amnesia are unlikely to occur.

TRANXENE®
(clorazepate dipotassium) C IV
Is Anxioselective™†



*Problem sedation is defined as moderate to severe degrees of sedation, sleepiness, drowsiness, or lassitude.

†Anxioselective refers to a drug whose most prominent action is anxiety reduction and which has less prominent other behavioral consequences.

For further details of this study, contact your Abbott representative.

Please see Brief Summary.

TRANXENE®
(clorazepate dipotassium) C-IV

Brief Summary of Prescribing Information

INDICATIONS—For management of anxiety disorders or short-term relief of symptoms of anxiety; for symptomatic relief of acute alcohol withdrawal; for adjunctive therapy in partial seizures

Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic. Effectiveness in long-term management of anxiety (over 4 months) not assessed by systematic clinical studies. The physician should periodically reassess usefulness for each patient

CONTRAINDICATIONS—Known hypersensitivity to the drug. Acute narrow angle glaucoma

WARNINGS—Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9 Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

Pregnancy and Lactation: Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers

PRECAUTIONS—Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated

ADVERSE REACTIONS—Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure.

INTERACTIONS—Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors and other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

OVERDOSAGE—Take general measures as for any CNS depressant.

SUPPLIED—TRANXENE 3.75, 7.5, and 15 mg capsules and scored tablets. TRANXENE-SD Half Strength 11.25 and TRANXENE-SD 22.5 mg single dose tablets

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Abbott Pharmaceuticals, Inc.
North Chicago, IL 60064

ISMS Holds Open House at New Headquarters Office

More than 600 people attended open house festivities Wednesday, February 13, at the new Chicago Headquarters of the Illinois State Medical Society, Illinois State Medical Insurance Services and the Illinois State Medical Inter-Insurance Exchange. The 5-7 p.m. open house marked the first public event since ISMS and the Exchange moved into the building in late October.

Among the distinguished guests were Illinois Lieutenant Governor George H. Ryan, Secretary of State Jim Edgar, Deputy Governor Jim Reilly, directors of state government departments, and a sizeable number of members of the Illinois General Assembly. Also attending were Dr. Joseph F. Boyle, American Medical Association president; Dr. Frank J. Jirka, AMA past president; Dr. John J. Coury, chairman of the AMA Board; Dr. James H. Sammons, AMA executive vice president; and several AMA trustees.

A wide array of other guests were present, including representatives of the ISMS Auxiliary, allied health associations, other state membership associations, legal firms providing defense services to Illinois State Medical Inter-Insurance Exchange policyholders, and medical society suppliers.

ISMS and Illinois State Medical Insurance Services lease the sixth and seventh floors of the renovated building that formerly housed the John M. Smyth furniture company. The front pillars of the limestone and granite facade now identify the structure as the Illinois State Medical Society building. The 41,000 square feet leased by the Society and ISMIS have been designed to permit efficient continuation of ISMS and ISMIS activities while providing expansion as needed in coming years.

Since ISMS entered into the building's development at an early stage of the renovation, the Society's unique requirements were integrated in the overall gutting and rehabilitation of the building. The space was designed essentially to specifications at minimal cost.

Optimal space has been provided for computer and other essential hardware. A state-of-the-art security system has been installed to ensure the safety of the Society's property and personnel. Technologically innovative electrical, heating and lighting systems ensure energy efficiency and environmental control. And a new telephone system now permits direct dial access to most staff members. ◀

Approach Each As An Individual

Legislators Are People Too

ISMS is engaged in a mammoth effort to encourage the Illinois legislature to pass malpractice reform provisions. The "action team" concept is a cornerstone of this project. Action teams are groups of physicians, organized through their county medical societies or hospitals, who seek to communicate with legislators, members of the media, community leaders and the public. This column is designed to augment that educational effort.

It's been said before, but it bears repeating: each legislator has his or her individual priorities, responsibilities and interests. There is no single "best" persuasive approach to use when seeking support for malpractice reform legislation.

Some legislators, for example, come from districts with a high proportion of blue collar constituents. These lawmakers need to know how the malpractice problem affects the cost of health care. This, in turn, affects their constituents' paychecks when employers are forced to pay higher costs for health benefits.

Other legislators represent different constituencies, such as small businessmen and farmers. These voters can sympathize with the private practice physician's headaches and identify with them. They know that operating costs—such as insurance premiums—translate into losses at year end. And they are more likely to be paying their own insurance premiums, and watching them increase.

Communicating With Legislators

Effective personal communication will be an essential element of the legislative effort this session. Meetings not only bring legislative support, they provide lobbying experience for action team members in a familiar atmosphere. Legislators, in turn, may appreciate a hospital invitation as an opportunity to meet constituents they might not otherwise encounter.

Follow-up is crucial. A legislator who takes the time to meet with action team members should always receive a written note of appreciation. The ISMS governmental affairs division should also be advised of each meeting; our lobbyists need to know which legislators have been contacted. It makes a difference.

Letters can be influential adjuncts to personal meetings with legislators. One hospital administrator has encouraged employees to write legislators in support of the legislative package, setting aside a hospital lounge with stationery for that purpose. Employees are asked to supply their own stamps and mail the letters from home.

Physicians should communicate with their legislators on a regular basis. Letters, mailgrams and personal visits are among the options. Repeated correspondence on varying themes related to the initiative can have an impact.

Media Coverage Important

The ISMS public relations division and staff coordinators can provide media "how to" guides for every action team. The guide outlines methods to generate media coverage of the issue. It also provides a prototype letter to the editor, fact sheet, feature story, press release and local media list.

Hard news stories and letters to the editor have been successfully generated by action teams. Meetings with legislators provide an excellent opportunity for a hard news story, and media coverage reinforces the importance of the issue in the legislator's mind. Action

teams are *not* encouraged to invite local media to legislative meetings; a press release detailing the event should be sent to the local newspaper a few days later. Photographs should be enclosed when possible.

ISMS will be continuing to use its "President's Tour" to generate news coverage. Press conferences and individual interviews with ISMS President Robert C. Hamilton, M.D., as well as local physicians, permit further coverage of the issue, stimulate media interest and provide the opportunity for making important media contacts.

Letters to the editor have successfully brought exposure to the malpractice crisis and its effects on health care costs. Physicians should submit letters to the editor typed on their personal or hospital letterhead. The sample letter from the ISMS media guide can provide a basic structure, but it's crucial that local references and comments be incorporated.

As the malpractice package will be introduced soon, action teams should begin to prepare for visits with local editorial boards. It's best to wait until the malpractice package is getting local news coverage before attempting to generate editorial endorsements. The media "how to" guide provides tips to encourge news coverage and editorial endorsements.

Update on Action Team Activity

Action teams formed by *Gottlieb Memorial Hospital,* Chicago, *St. Mary's Hospital,* Streator and the *Saline-Pope-Hardin County Medical Society* have successfully generated publicity for meetings with their legislators. . . . *Lake County Medical Society* Executive Secretary Jane Stein's letter to the editor of the Deerfield Voice and Waukegan Sun outlined the problem and urged that readers write their legislators. . . . Jim Koch, *Rock Island County Medical Society* executive secretary, wrote a letter to commend a Quad City Times editorial on how the malpractice crisis relates to health care costs. Mr. Koch saw an opportunity to reiterate local support as well as re-emphasize the salient points of the editorial.

Alexian Brothers Hospital will host a breakfast for the 12 legislators representing its patient population. A program on the malpractice problem is scheduled, and a tour of the hospital is planned to reinforce its role as a major economic force and employer in the community. . . . The *Danville County Medical Society* action team, headed by Ed Warren, M.D., has opted for a more intimate dinner setting to meet with its local legislator. . . . A mass meeting with the entire *DuPage County* legislative delegation is being arranged. The group format was selected because of the large number of hospitals in that county. . . . One enthusiastic legislator has suggested that the *Edward Utlaut Hospital* action team ask each legislator to co-sponsor one or more bills. That personal contact makes a difference!

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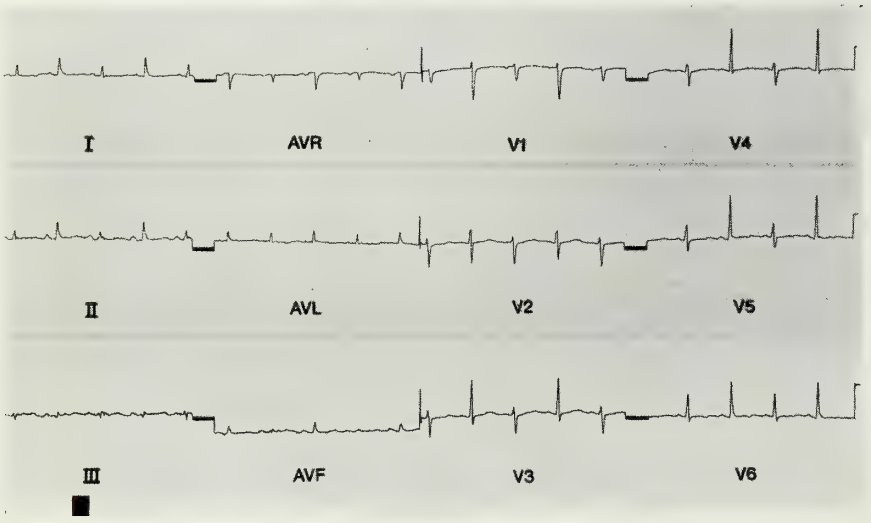
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EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This patient is a 41 year old man who came to the clinic with a three day history of worsening dyspnea. Although he thought it might be flu, he was concerned because of his history of cancer. Several months earlier a diagnosis of metastatic adenocarcinoma from an unknown primary was made. At that time, he had a picture of migratory thrombophlebitis and suffered a pulmonary embolus. Although no primary tumor was found, mediastinoscopy and biopsy demonstrated lymph nodes positive for tumor. The diagnosis of pulmonary embolus plus a suspicion of more than one pulmonary embolus prompted the use of anticoagulation. His physical examination now showed a pulse rate of 120 beats per minute and a blood pressure of 100/80mmHg with an 18mmHg pulsus paradoxus. He had jugular venous distension to the angle of the jaw in a supine position of 45°. His lungs were clear to auscultation and no pericardial friction rub was heard. A chest x-ray showed cardiomegaly. This twelve lead ECG was obtained.

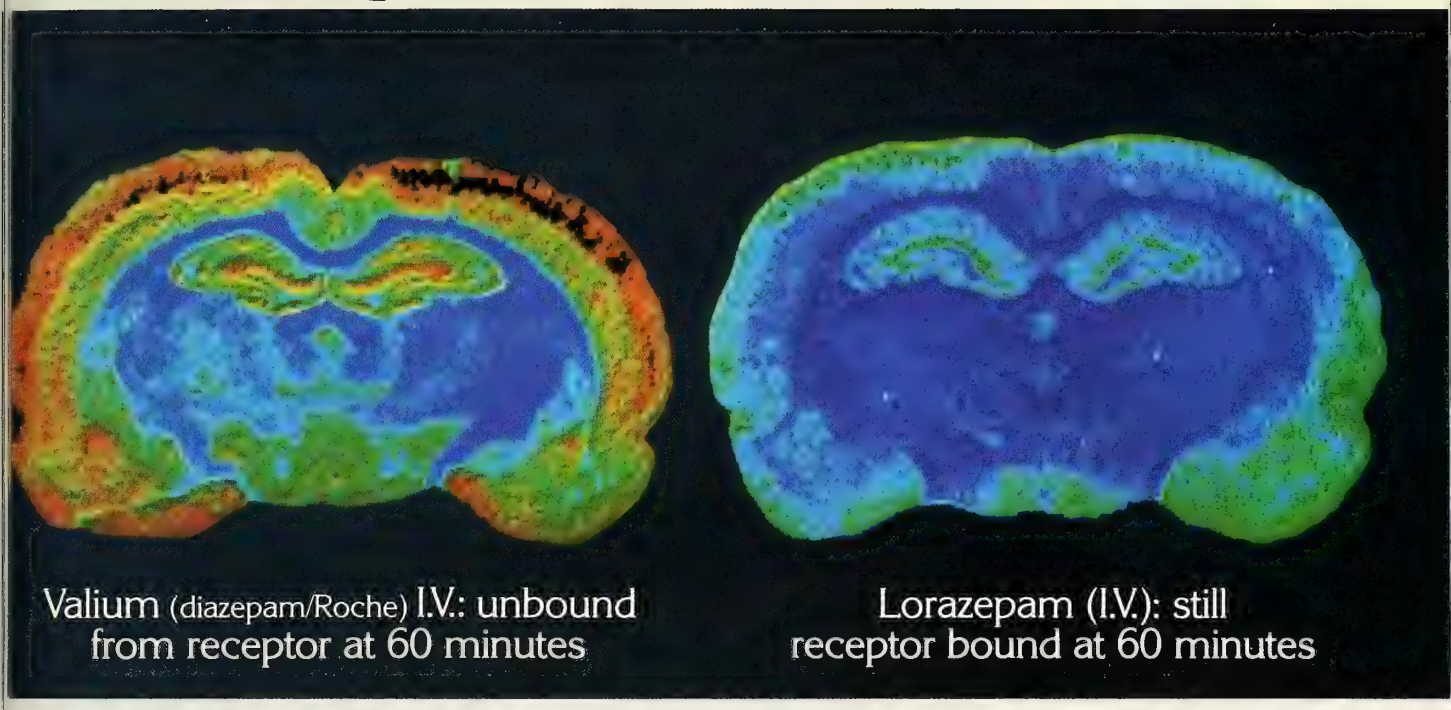
Questions:

1. **The twelve lead ECG shows:**
 a. Premature atrial beats with aberrant intraventricular conduction occurring in bigeminy.
 b. Premature ventricular beats in bigeminy.
 c. Alternating bundle branch block pattern.
 d. Electrical alternans.
 e. Probably normal ECG except for sinus tachycardia.

2. **The following statement(s) is/are true.**
 a. An echocardiogram may be helpful here.
 b. A malignant tumor as well as anticoagulation are often associated with this medical problem.
 c. Dyspnea is a common presenting complaint.
 d. Pulsus paradoxus is an accentuation of a normal process.
 e. All of the above.

(Continued on page 194)

occupancy of was faster and of shorter of lorazepam*



Valium (diazepam/Roche) I.V.: unbound from receptor at 60 minutes

Lorazepam (I.V.): still receptor bound at 60 minutes

The results:

Diazepam receptor occupancy peaked at 30 seconds after dosing and returned to baseline in 60 minutes. Peak lorazepam receptor occupancy did not occur until 10 minutes after dosing and continued to be strongly in evidence after 60 minutes, with 45% occupancy still being observed.

The exact nature of the correlation between benzodiazepine binding sites and receptors in relation to clinical effect is still being defined. Considerable evidence supports the correlation. Although these animal results are consistent with clinical experience concerning relative duration of action, direct human data on receptor binding and human effects are still under investigation.

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Please see next page for summary of product information.



Valium® (diazepam/Roche)℞ Tablets
Valrelease® (diazepam/Roche)℞ slow-release Capsules
Injectable Valium® (diazepam/Roche)℞

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome. *Oral forms* may be used adjunctively in convulsive disorders, but not as sole therapy. *Injectable form* may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion.

The effectiveness of diazepam in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets or capsules in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because their use is rarely a matter of urgency and because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins,* i.e., *dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Injectable Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least ⅓, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, *i.e.,* phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed and tolerated).

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug. Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and after diazepam therapy are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia. In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Valium® (diazepam/Roche)
Valrelease® (diazepam/Roche)
Injectable Valium® (diazepam/Roche)

Dosage: Individualize for maximum beneficial effect.

ORAL: *Adults:* Anxiety disorders, relief of symptoms of anxiety—Valium tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 Valrelease capsules (15 to 30 mg) daily. Acute alcohol withdrawal—tablets, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 capsules (30 mg) the first 24 hours, then 1 capsule (15 mg) daily as needed. Adjunctively in skeletal muscle spasm—tablets, 2 to 10 mg t.i.d. or q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. Adjunctively in convulsive disorders—tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. *Geriatric or debilitated patients:* Tablets—2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (see Precautions). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose. *Children:* Tablets—1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use in children under 6 months). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose (not for use in children under 6 months).

INJECTABLE: Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.)

For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., *dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcohol withdrawal, 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children *administer I.V. slowly;* for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary; in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly, repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary, keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension. Dialysis is of limited value.

How Supplied:

ORAL: Valium round, scored tablets with a cut out "V" design—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100 and 500; Prescription Paks of 50, available in trays of 10. Tel-E-Dose® packages of 100, available in boxes of 4 reverse-numbered cards of 25, and in boxes containing 10 strips of 10.

Valrelease slow-release capsules—15 mg (yellow and blue), bottles of 100; Prescription Paks of 30.

INJECTABLE: Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

ROCHE®

Obituaries

***Barnes, Charles K.,** Chicago, died February 11, 1984 at the age of 84. Dr. Barnes was a 1925 graduate of Northwestern University Medical School.

Benson, Donald W., Hyde Park, died January 21, 1985 at the age of 63. Dr. Benson was a 1950 graduate of the University of Chicago Pritzker School of Medicine.

****Brandenberger, Arthur R.,** Danville, died January 15, 1985 at the age of 83. Dr. Brandenberger was a 1929 graduate of the University of Illinois College of Medicine, Chicago.

****Dina, Salvatore,** Chicago, died January 14, 1985 at the age of 81. Dr. Dina was a 1934 graduate of Rush Medical Colllege, Chicago.

****Faller, Adolph,** Chicago, died January 28, 1985 at the age of 76. Dr. Faller was a 1933 graduate of Northwestern University Medical School.

***Flanagan, George C.,** Riverside, died January 29, 1985 at the age of 56. Dr. Flanagan was a 1953 graduate of the University of Chicago Pritzker School of Medicine.

****Halevy, Arthur A.,** Chicago, died January 18, 1985 at the age of 79. Dr. Halevy was a 1930 graduate of the University of Illinois College of Medicine, Chicago.

Horowitz, John J., Beverly Hills, California, formerly of Kankakee, died December 7, 1984 at the age of 76. Dr. Horowitz was a 1932 graduate of New York Medical College.

****Johnston, Joseph A.,** Port St. Lucie, Florida, died January 12, 1985 at the age of 95. Dr. Johnston was a 1915 graduate of Bennett Medical College, Chicago.

***Kobak, Mathew W.,** Flossmoor, died January 16, 1985 at the age of 67. Dr. Kobak was a 1941 graduate of Rush Medical College, Chicago.

****Lewandowski, Henry C.,** Frankfort, died January 31, 1985 at the age of 79. Dr. Lewandowski was a 1933 graduate of the University of Health Sciences/Chicago Medical School.

****Longwell, Charles W.,** Nashville, died November 13, 1984 at the age of 77. Dr. Longwell was a 1932 graduate of Northwestern University Medical School.

***Ranquist, Robert C.,** Frankfort, died February 7, 1985 at the age of 74. Dr. Ranquist was a 1936 graduate of Rush Medical College, Chicago.

****Rytel, Alexander,** Elm Grove, died November 15, 1984 at the age of 73. Dr. Tobey was a 1940 graduate of The University of Health Sciences/Chicago Medical School.

****Sabin, Allen L.,** St. Petersburg, Florida, formerly of Sullivan, died January 17, 1985 at the age of 85. Dr. Sabin was a 1930 graduate of the University of Illinois College of Medicine, Chicago.

****Smith, Stanton G.,** Decatur, died January 18, 1985 at the age of 78. Dr. Smith was a 1931 graduate of the Washington University School of Medicine, St. Louis.

***Stone, Calvin F.,** Highland Park, died January 16, 1985 at the age of 74. Dr. Stone was a 1935 graduate of Northwestern University Medical School.

***Tobey, Albro C.,** McLeansboro, died November 26, 1984 at the age of 73. Dr. Tobey was a 1940 graduate of The University of Health Sciences/Chicago Medical School.

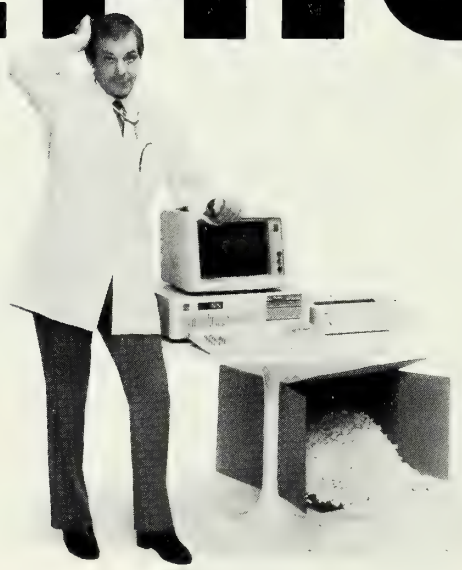
***Whitfield, Lawrence A.,** Chicago, died January 4, 1985 at the age of 74. Dr. Whitfield was a 1945 graduate of the University of Illinois College of Medicine, Chicago.

****Winskunas, Felix C.,** Chicago, died January 9, 1985 at the age of 76. Dr. Winskunas was a 1932 graduate of the Loyola University Stritch School of Medicine, Maywood.

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Otolaryngology, Head-Neck Surgery

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Stays on better

Reformulated adhesive delivers optimum staying power. Results of two studies* with both placebo and active systems on normal subjects proved that Transderm-Nitro has an almost 100% adhesion rate, even under the most adverse conditions, including hot, humid summer weather.

Handles better

Clear plastic 3M backing is easy to remove — practically slides right off. There's no risk of your patient damaging the system. Especially easy to handle for elderly patients.

Comes off without significant irritation

The reformulated adhesive is strong, yet gentle on the skin. The studies* also showed no significant irritation after removal.

Contraindicated in patients with intolerance to organic nitrate drugs.

All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA. (See Brief Summary of Prescribing Information on the next page.)

*Data on file, CIBA Pharmaceutical Co.

Transderm®-Nitro

(nitroglycerin)
Transdermal Therapeutic System

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)*

INDICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.

In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.

Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.

Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.

Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea, vomiting, and dermatitis. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued.

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.

The usual dosage is one Transderm-Nitro 5 system every 24 hours. Some patients, however, may require the Transderm-Nitro 10 system. If a single Transderm-Nitro 5 system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 systems or one Transderm-Nitro 10 system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone.

The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.

Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

HOW SUPPLIED

Transderm-Nitro System Rated Release *in vivo*	Total Nitroglycerin in System	System Size	Carton Size
2.5 mg/24 hr	12.5 mg	5 cm^2	30 Systems (NDC 0083-2025-26)
5 mg/24 hr	25 mg	10 cm^2	30 Systems (NDC 0083-2105-26)
5 mg/24 hr	25 mg	10 cm^2	7 Systems (NDC 0083-2105-07)
10 mg/24 hr	50 mg	20 cm^2	30 Systems (NDC 0083-2110-26)
15 mg/24 hr	75 mg	30 cm^2	30 Systems (NDC 0083-2115-26)

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THE VIEWBOX

CONTRIBUTING EDITOR TERRENCE C. DEMOS, M.D., PROFESSOR OF RADIOLOGY, DEPARTMENT OF RADIOLOGY, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was prepared by Mary G. Cormier, M.D., Department of Radiology, Loyola University Medical Center, Maywood, Illinois.

A 21 year old man with chronic granulocytic leukemia had undergone bone marrow transplant. His chest radiograph prior to transplant was normal (Fig. 1). A chest radiograph taken five weeks after transplant is shown (Fig. 2). He had a mild cough and dyspnea.

Figure 1A—Normal chest radiograph.

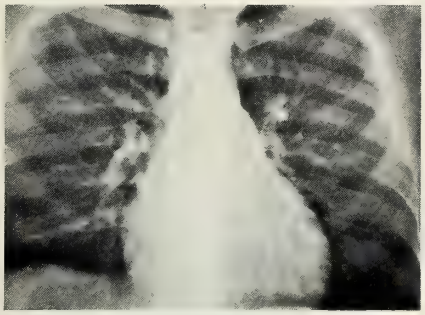


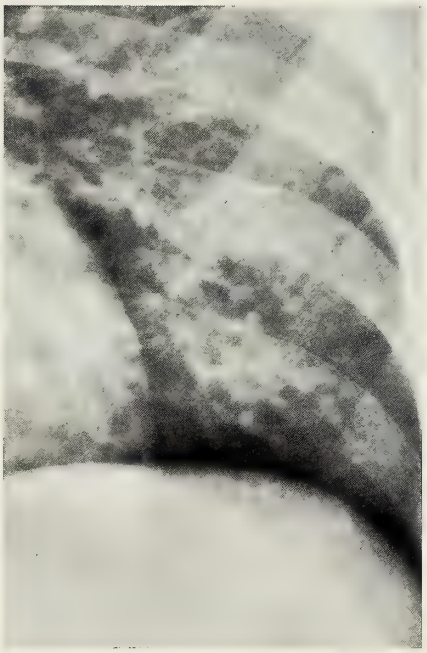
Figure 1B—Close up of normal left lung.



Figure 2A—Diffuse reticulonodular lung densities 5 weeks after bone marrow transplant.



Figure 2B—Close up of reticulonodular densities which obscure the normal blood vessels.



Your diagnosis?

(1) Cytomegalovirus infection
(2) Leukemic lung involvement
(3) Acute pulmonary hemorrhage
(4) Graft versus host disease

(Continued on page 246)

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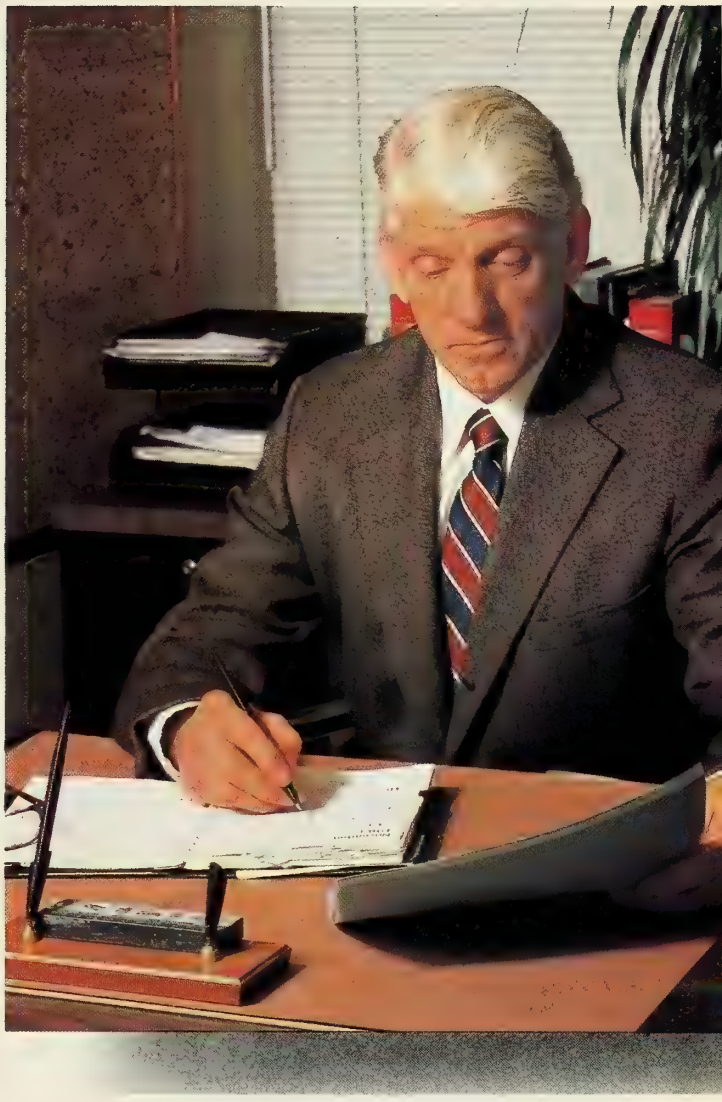
WITH COMPLETE SLEEP LABORATORY PROOF[1-5]...

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IN ALL THESE WAYS

- Rapid sleep onset[1-6]
- Effective for middle-of-the-night and early-morning awakenings[2,5]
- Undiminished efficacy for at least 28 nights[2-4]
- Patients usually awake rested and refreshed[7-9]
- Avoids rebound insomnia after discontinuation of therapy[3,5,10-12]

Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.



AND THE PREDICTABILITY THAT COMES WITH EXPERIENCE

FOR EFFECTIVE RELIEF OF INSOMNIA

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15-MG/30-MG CAPSULES

See next page for references and summary of product information.

References: **1.** Kales J *et al: Clin Pharmacol Ther* 12:691-697, Jul-Aug 1971. **2.** Kales A *et al: Clin Pharmacol Ther* 18:356-363, Sep 1975. **3.** Kales A *et al: Clin Pharmacol Ther* 19: 576-583, May 1976. **4.** Kales A *et al: Clin Pharmacol Ther* 32:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol* 3:140-150, Apr 1983. **7.** Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981. **8.** Greenblatt DJ *et al: Sleep* 5 (Suppl 1):S18-S27, 1982. **9.** Kales A *et al: Pharmacology* 26:121-137, 1983. **10.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977. **11.** Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. **12.** Amrein R *et al: Drugs Exp Clin Res* 9(1):85-99, 1983.

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flurazepam HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided, with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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EKG

(Continued from page 176)

Answers: 1. D 2. E

The twelve lead ECG shows sinus tachycardia at a rate of 120 beats per minute. The rhythm is regular and the PR interval and QRS duration are normal. There is electrical alternans of the QRS best seen in the precordial leads, especially V_3V_4 and V_5. Although alternans of the P and T waves has been described, it is not present here. Electrical alternans is strongly suggestive of pericardial tamponade and is caused by the pendular swinging of the heart in the pericardial fluid. An echocardiogram can be very helpful since it will demonstrate the pericardial effusion. In our patient, a large pericardial effusion was present. Aside from demonstrating the pericardial effusion, the echocardiogram can help with differential diagnosis of other causes of venous hypertension such as left or right ventricular dysfunction. The typical features of cardiac tamponade are a fall in arterial pressure especially with a marked pulsus paradoxus, an increased jugular venous pressure and a small quiet heart by examination. Pulsus paradoxus refers to the inspiratory fall in aortic systolic pressure and can be normal up to a 10mmHg fall. More than 10mmHg paradox is probably abnormal but can be seen in pulmonary disease such as emphysema, bronchitis, or massive pulmonary embolus in addition to cardiac tamponade. If the tamponade develops slowly, the patient may be acutely ill but not in shock. In this setting, dyspnea is usually a major complaint. Pericardiocentesis was only partially successful in removing the pericardial effusion and the fluid reaccumulated. The patient was sent for a thoracotomy and pericardial window. At surgery, 1000cc of pericardial fluid was removed and the pericardium looked normal. A cell block performed on the pericardial fluid was positive for malignancy consistent with adenocarcinoma. The pericardial biopsy was positive only for findings of chronic pericarditis. In our institution as well as others, malignant neoplasm is a common cause of cardiac tamponade. In other patients, anticoagulation is a common factor in the etiology of cardiac tamponade. ◀

Abstracts of Board Actions

(continued from page 181)

COMMITTEE ON DRUGS & THERAPEUTICS

The Board approved the following drug products for inclusion in the IDPA Drug Manual: GAVISCON ANTACID TABS (Alum. Hydroxide Gel/Magnesium Trisilicate); TONOCARD (Tocainide HCL); TRENTAL (Pentoxifylline); MAXZIDE (Hydrochlorothiozide/Triamtrene); ISORDIL TITRADOSE 40 mg oral (Isosorbide Dinitrate); INFALYTE 6mg Pkts (Oral Electrolyte) and TRIPHASIL ORAL CONTRACEPTIVE (Ethinyl Estradiol/Levonorgestrel).

The Board also recommended that the following drugs not be included in the IDPA Drug Manual: NEOTEC (Povidone—Iodine 1% Sol.); BETADINE ANTISEPTIC GEL (Povidone—Iodine 10% Vaginal Gel); DILANTIN MEMOPAK (4 cards/3 rows/7 capsules ea.); CATEPRES TTS (Clonidine—in a—patch) and AMBENYL COUGH SYRUP (Bromodiphenhydramine HCL/Codeine Phosphate).

The Board further recommended that Aldactone-50mg and Aldactazide—50/50 not be included in the Drug Manual.

OTHER ACTIONS

In addressing various other issues, the Board:

- Approved the 1985 budget as presented. Accepted the Financial Statements for the period ended September 30, 1984; December 28, 1984, IMPAC Collection Data Report; December 28, 1984, Membership Dues Payment Report; and Requests for Changes in Membershp Status.
- Directed that a letter be sent to the Bar Association supporting continued discussion of needed professional liability reforms.
- Agreed to continue monitoring the hold harmless issue and bring legal action when appropriate.
- Agreed that, at the present, a proposed survey on unified membership not be undertaken in light of the AMA action to provide various benefits to members of unified societies, including a 10% reduction in AMA dues beginning in 1985. Further consideration of a survey will be reviewed prior to the 1986 annual meeting.
- Directed that each county medical society be surveyed to determine each society's opinion with regard to a mechanism for notifying members of eligibility for emeritus status, and that results of the survey be reported to the Board at its April meeting.
- Directed that the Council on Governmental Affairs develop legislation regarding "clinical training" provided by medical schools not recognized by the Illinois Department of Registration and Education.
- Referred to the Executive Committee for further consideration and development a physician's statement to patients designed to develop increased public support for the Professional Liability Initiative.
- Directed that the Governmental Affairs Council develop a resolution for the 1985 annual meeting requesting that ISMS recognize the public health problem and related health care costs caused by driving under the influence (DUI).
- Agreed to support the development of legislation to govern the use of the term "emergency" by health facilities.
- Referred to the Council on Medical Services consideration of a request for distribution of information from the Illinois Society for Medical Research to Illinois physicians, concerning the need for animals in medical research.
- Directed that ISMS appoint a representative to serve on the advisory committee to design a University of Illinois study of low birth weight infants.
- Agreed to contribute $150 to the Interagency Council on Smoking and Disease.
- Approved the development of a research study to determine the effectiveness of loss prevention education programs.
- Approved the publication and distribution of a resource directory of impaired physician treatment programs.
- Accepted for submission to the 1985 ISMS House of Delegates, a resolution to amend the Bylaws abolishing the requirement that county medical societies submit annual roster information to ISMS.
- Approved an unfinished business report for the 1985 annual meeting pertaining to patient communication. (Res. 24 A-84)

PROGRAMS

The Board agreed to continue its support of the Prairie State Games, through the provision of medical advice to the games organizers.

AWARDS

The Board directed that the following physicians receive the 1985 ISMS Team Physician Award: Drs. Donald Dester, Macomb; Jerry D. Heath, Charleston; Joseph F. Hinkamp, Glenview; John McDonnell, Sterling; John Steinkamp, Belvidere and Richard Temple, Geneva.

NOMINATIONS

Acting on recommendations of the Councils and Executive Committee, the Board:

- Nominated Dr. Stanley M. Zydlo, Jr., for reappointment to the State Emergency Medical Services Council.
- Nominated Dr. C. Larkin Flanagan for the Chicago Lung Association Advisory Council.
- Nominated Drs. P.F.D. Van Peenen, director of epidemiology, Standard Oil Company; Brian H. Huncke, research associate, Marianjoy Rehabilitation Hospital and Marvin Rosner, chairman, ISMS Maternal Welfare Committee, for an IDPH Ad Hoc Committee for the Health & Hazardous Substances Registry.
- Nominated the following physicians for appointment to the Experimental Organ Transplantation Procedures Board:
 - Henry P. Russe, M.D.—dean of Rush Medical College
 - Donald West King, M.D.—executive dean, Division of Biological Sciences, Pritzker School of Medicine and executive vice president for the Medical Center.
 - Roque Pifarre, M.D.—heart transplant surgeon, Loyola Medical Center
 - Robert B. Karp, M.D.—professor, Department of Surgery and chief, Cardiac Surgery Section—University of Chicago
 - Richard J. Sassetti, M.D.—director of the Blood Center at Rush-Pres.-St. Luke's Hospital
 - Randy A. Kienstra, M.D.—A Springfield board certified pediatric nephrologist
 - Craig R. Reckard, M.D.—professor of surgery—Loyola University Medical Center
 - John B. O'Connell, M.D.—director of the Cardiac Transplantation Program—Loyola University Medical Center
 - John Robinson, M.D.—chief of Clinical Immunology—Loyola University Medical Center
 - Lawrence M. Gartner, M.D.—professor and chairman, Department of Pediatrics and Director of Wyler's Children's Hospital
 - Bann Kang, M.D.—chief, Division of Allergy and Clinical Immunology, Mt. Sinai Hospital Medical Center
 - Jerry Staub, M.D.—director of Pediatric Intensive Care Unit, Swedish American Hospital

INFORMATIONAL ITEMS

The Executive Administrator reported on the Professional Liability Initiative, physician contracting, the House Judiciary Sub-Committee on Medical Malpractice and a change proposed for the medical discipline act.

NEXT MEETING

The Board set the next Board of Trustees meeting for April 25-28, 1985, at the Chicago Marriott O'Hare.

A Symposium for Psychiatrists:

FINANCIAL SURVIVAL

in a Rapidly Changing Health Care Market

Rapid changes in health care economics and regulations don't need to threaten your financial survival. Jeff Goldsmith, Ph.D., one of the nation's leading health care consultants, has helped psychiatrists across the country maintain their professional independence and financial security within the new competitive health care market. Dr. Goldsmith will present provocative ideas and practical approaches to reimbursement issues, hospital-psychiatrist partnerships, physician marketing, and business planning to assure economic viability.

Friday, April 12, 1985 1-5 p.m.
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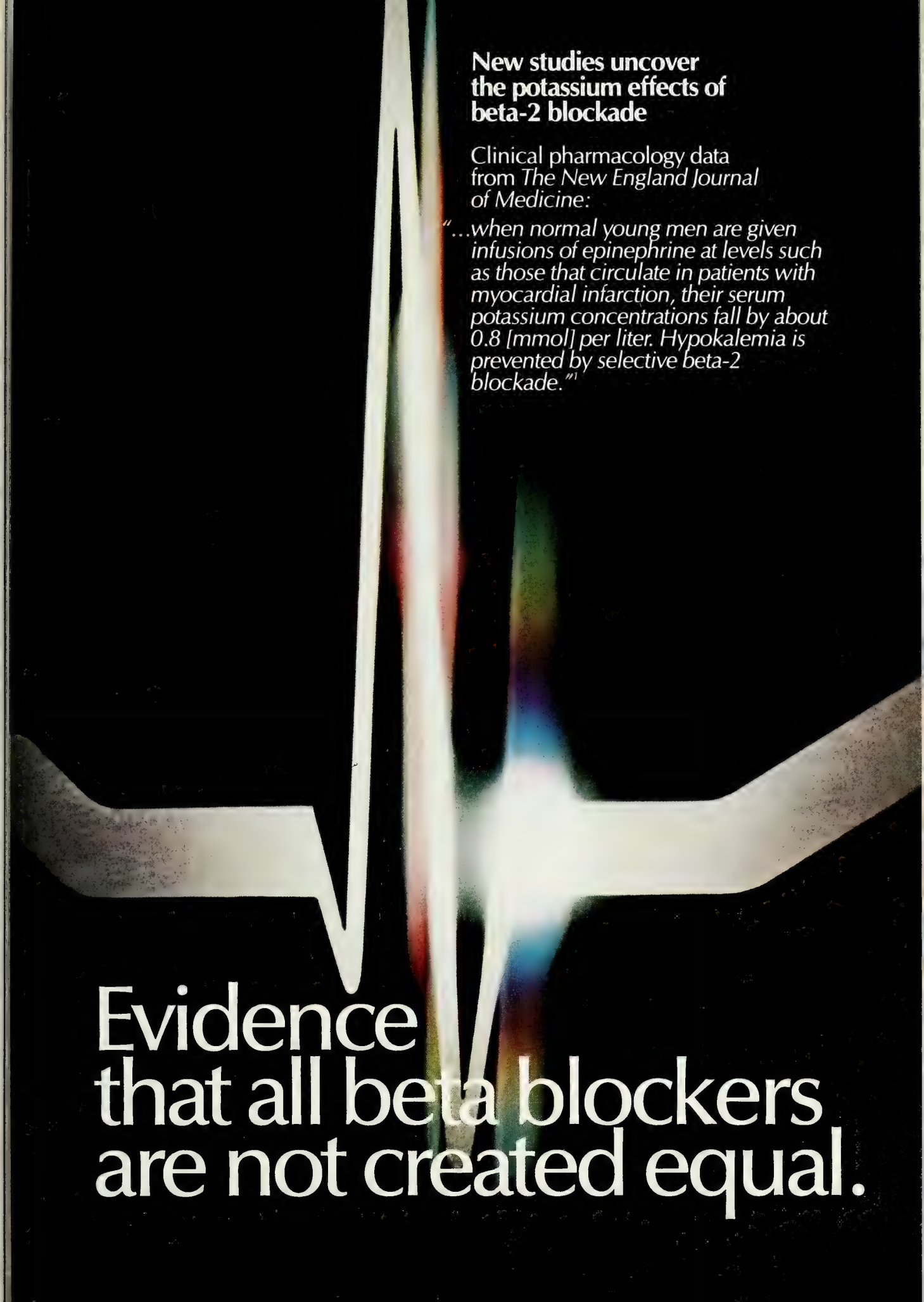
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New studies uncover the potassium effects of beta-2 blockade

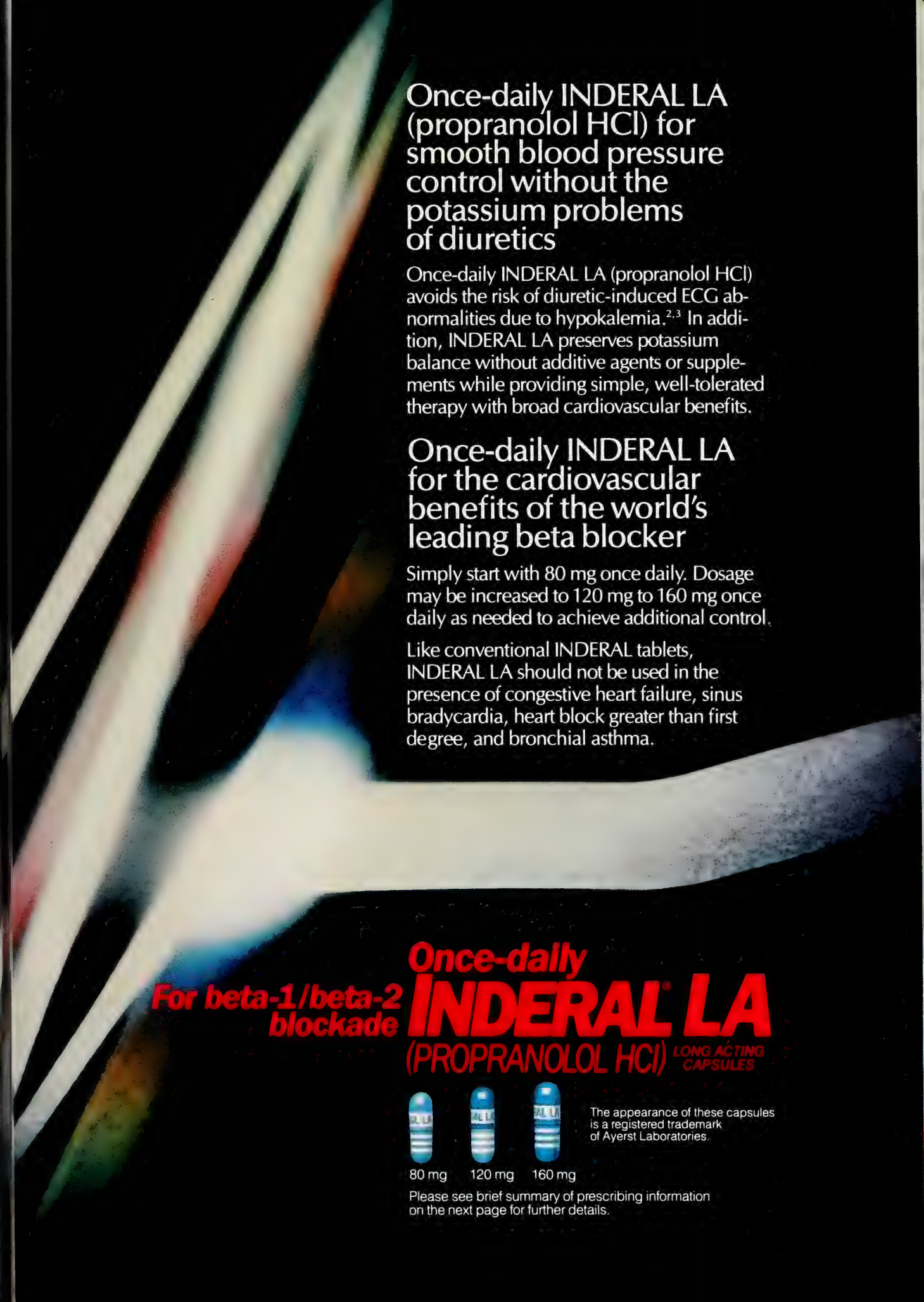
Clinical pharmacology data from *The New England Journal of Medicine:*

"...when normal young men are given infusions of epinephrine at levels such as those that circulate in patients with myocardial infarction, their serum potassium concentrations fall by about 0.8 [mmol] per liter. Hypokalemia is prevented by selective beta-2 blockade."[1]

Evidence that all beta blockers are not created equal.

Right from the start in hypertension...





Once-daily INDERAL LA (propranolol HCl) for smooth blood pressure control without the potassium problems of diuretics

Once-daily INDERAL LA (propranolol HCl) avoids the risk of diuretic-induced ECG abnormalities due to hypokalemia.[2,3] In addition, INDERAL LA preserves potassium balance without additive agents or supplements while providing simple, well-tolerated therapy with broad cardiovascular benefits.

Once-daily INDERAL LA for the cardiovascular benefits of the world's leading beta blocker

Simply start with 80 mg once daily. Dosage may be increased to 120 mg to 160 mg once daily as needed to achieve additional control.

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

For beta-1/beta-2 blockade

Once-daily

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES

80 mg 120 mg 160 mg

The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Please see brief summary of prescribing information on the next page for further details.

Once-daily For beta-1/beta-2 blockade INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



The appearance of these capsules is a registered trademark of Ayerst Laboratories.

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

REFERENCES

1. Epstein FH, Rosa RM: Adrenergic control of serum potassium. *N Engl J Med* 1983; 309:1450-1451. **2.** Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768. **3.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299

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Interim Meeting Summary

By Rich Terek, Chairman, ISMS/MSS

The 1984 Medical Student Section interim meeting began on December 2 in Honolulu, Hawaii, with educational seminars on residency selection, financial aid, and changes in Medicare. The MSS assembly then convened to consider 30 resolutions, 13 reports and one position paper. Seven of the resolutions were forwarded to the AMA House of Delegates for their consideration. Five of the resolutions were adopted as amended, one was referred for further study, and one was not adopted.

Resolution 79, "Hepatitis vaccine for medical students," resulted in the AMA's urging all medical schools to implement an effective program which will address the increased risk to medical students of contracting Hepatitis B. One clearly effective program from both a cost/benefit and efficacy perspective is the Hepatitis B vaccine. If your school does not currently provide the vaccine to students or if the cost is prohibitive, it might be worth your while to discuss current AMA policy with your dean or hospital infectious disease department and ask that they provide the vaccine to students as an effective, worthwhile program.

Good news for those of you on the ten year plan. The AMA supports the concept of shared residencies and will encourage residency program directors to offer such positions where feasible.

In response to the recent bombings of abortion clinics, the AMA adopted MSS sponsored resolution 82, "Violence against medical facilities." This resolution reaffirms the AMA's support of the right to access to medical care, and states that the AMA opposes violence directed against any medical facility, including abortion clinics and family planning centers.

The federal government is considering many additional strategies for controlling health care costs. One of these is to withhold payment for that part of medical care costs attributable to graduate medical education. This would include housestaff and faculty salaries, and the extra costs of care in teaching hospitals attributable to tests and procedures ordered by housestaff for educational purposes. Report E of the Council on Medical Education deals with these issues and was adopted in lieu of Resolution 83 "Financing Graduate Medical Education," which endorses the principle that all third party payors support both the direct and indirect costs of graduate medical education.

AMA resolution 80, introduced by Gail Herman of the University of Illinois, calls for the AMA to support a "transitional class" of drugs in addition to the present classification of drugs as either over-the-counter or prescription. This was reversed to establish the AMA's opposition to the creation of a transitional class of drugs.

The AMA is investigating the possibility of publishing an obstetrics/gynecology specialty journal. A decision is likely to be made at the next meeting.

The MSS assembly approved the following ranking of nominees for the student non-voting seat on the AMA Board of Trustees: (1) David Brailer, West Virginia University School of Medicine; (2) Brian McGrath, State University of New York at Buffalo. The Board of Trustees will evaluate these nominees, taking into account the MSS ranking, and select a student sometime this spring.

The following students from Illinois participated in the meeting: David O'Brien, Hal Bennett, David Margolis, Gail Herman, Nancy Zamora, Phil Miers, Mark Dobertein, Tom Zusag, Greg Gullahorn, Karen Kawala, Lauren Baker, Rich Terek, John Kall and Scott Green.

The next meeting of the AMA and MSS will be in June, 1985. If you have any ideas for resolutions which you would like the AMA to consider, please forward them to the ISMS/MSS or to your school delegate. The deadline for submission is May 3.

Other important dates to mark on your calendar are the Chicago Medical Society Career Day on April 13, the Annual ISMS meeting April 26-28 and MSS annual meeting and elections April 27. There will be a seminar on the economic rationale of competition and DRGS in medicine and their ethical implications. This will be followed by lunch, election of next year's officers and nomination of student reps to the various ISMS councils.

The ISMS will meet and consider its own business as well as resolutions submitted by students. Again, if you have any issues which you feel are best addressed on the state level, please bring them to the attention of your school delegate for submission before March 22. Please watch for the school newsletters which will be distributed in March for more information about the upcoming election and meeting. ◀

PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602.

BLOOMINGTON:
Internal Medicine—To join an active six member IM practice in mid-western university community. A sub-specialty in Rheumatology, Endocrinology, or Allergy is desirable, but not necessary. Contact: J. Buchanan, The Health Center, 702 N. East St., Bloomington 61701 (309-827-5051). (2)

BRADFORD:
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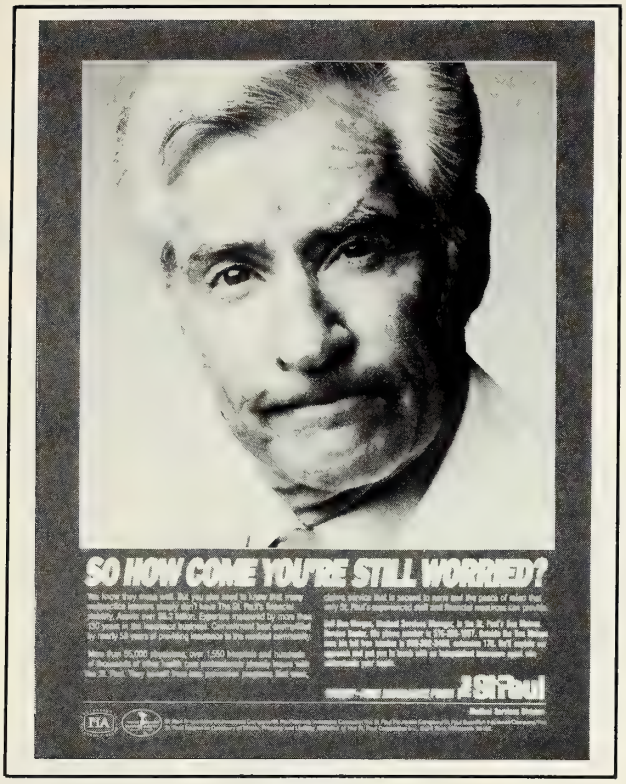
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MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

The Veterans Administration coronary bypass surgery cooperative study group randomly assigned 686 patients to medical and surgical care for treatment of coronary disease at 13 hospitals and followed these patients for 11 years. Patients with three coronary vessel involvement and impaired ventricular function when treated medically showed a survival rate of 52% contrasted to 76% when treated surgically at the end of seven years. At the end of 11 years the survival rates were 38% and 49% respectively. Among patients exhibiting two of three specified criteria (resting ST depression, history of myocardial infarction, or history of hypertension) the survival rate at the end of seven years was 52% in the medical group, 76% in the surgical group and at the end of 11 years the rates were 36% and 49% respectively. The surgically treated group with stable ischemic heart disease benefited for the first seven years but thereafter the survival benefit gradually diminished. (Detre, K.M., *et al.: NEJM* 311:1333-1338, 1984)

The second national health and nutrition examination survey examined a representative sample of the U.S. population and found that lead blood levels were related to the ambient environmental exposures. A direct relationship was found between the blood lead level and the systolic and diastolic blood pressures in men and women, particularly between the ages of 21-55 years and inversely related to the dietary and zinc levels. (Harlan, W.R. *et al.: JAMA* 253#4:530-4, 1985)

Frail, elderly inpatients with high probability of nursing home placement were randomly assigned as control group (60 cases) or to a comprehensive geriatric center (63 cases) offering rehabilitation services. At the end of one year the control group showed a mortality rate of 48.3%, while 30% required nursing home placement, and required substantially more acute care hospital stays and days. The geriatric care group had a mortality rate of only 23.8%, required nursing home stays in 12.7% of cases, showed improved functional capacities and morale, and offered reductions in health care costs. (Rubenstein, L.Z. *et al: NEJM* 311:26, 1664-70, 1984)

An Epstein-Barr virus infection may not be self-limiting, and may result in pharyngitis, lymphadenopathy, fever, arthralgia, headache, fatigue, depression, dyslogia, and myalgia as well as infectious mononucleosis in children and adults. Twenty six adults and 18 children under 15 years of age with the above symptoms were tested for antiviral capsid antigen and anti-early antigen titers. They were significantly greater in these patients than in the control group. (Jones, J.F. *et al.: Ann. Int. Med.* 102#1:1-7, 1985)

A restrospective analysis of 114 black patients showed a 15.9% incidence of esophageal cancer with a 1.6% survival rate at the end of five years. The overall incidence of esophageal carcinoma in the U.S. white population is six per 100,000, contrasted to an incidence of 20 per 100,000 in the black population. A family history of cancer was reported by 63.8% of whites and 7.48% of blacks. The initial complaints were dysphagia, odynophagia, epigastric and chest distress or pain. The etiology presents an enigma despite specific geographic, environmental, dietary, hereditary, and social factors. In this study, 13.5% of blacks were heavy smokers as contrasted to 82.1% of whites. (Smith, E.B.: *J Nat. Med. Assoc.* 77;1:44-8, 1985)

Patients with clinically suspected deep-vein thromboses and normal impedance plethysmography were randomly assigned to either serial impedance plethysmography alone or combined with leg scanning. Deep-vein thrombosis was detected in six of 311 cases (1.9%) by serial impedance plethysmography alone and in 30 of 323 patients (9.3%) using the combined approach. The authors conclude that impedance plethysmography appears accurate for proximal vein thromboses, but is insensitive to calf-vein thrombi. (Hull, R.D. *et al.: Ann. Int. Med.* 102:1, 21-8, 1985)

High energy defibrillation is recommended in a Mayo Clinic study of defibrillated patients seen by emergency teams. In 101 cases of ventricular fibrillation, nine of 16 cases who did not respond to low or intermediate energies were successfully defibrillated with high energy shocks. The 360-J maximal energy dose available in most instruments should be the initial dose with concomitant antiarrhythmic drugs and correction of metabolic abnormalities to increase survival, since a high percentage of patients revert to ventricular fibrillation. (Morgan, J.P. *et al: Mayo Clin. Proc.* 59:12, 829-34, 1984)

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Coccidioidal Meningitis

By Larry Miller, M.D., Janardan D. Khandekar, M.D., Francis V. Cook, M.D. and Eleanor Rabin, M.D./Evanston and Chicago

Coccidioides immitis is a soil fungus found in large portions of California, Arizona, New Mexico, Texas, Central America and South America.[1] These endemic areas are tourist attractions, and travelers contracting the disease may not show its manifestations until long after they have returned home.[2] We are presenting a case of coccidioidal meningitis, diagnosed in Illinois, to alert physicians of this potential life-threatening condition in non-endemic areas.

This 73-year-old white female had been diagnosed with breast cancer in 1977. She had undergone a modified radical mastectomy with adjuvant chemotherapy. The patient later developed local chest wall recurrence for which she had been treated with radiation. Further local recurrence and possible rib metastasis were treated first with tamoxifen citrate and then with a progestational agent which she had taken for one year prior to the present admission.

This patient presented six years after surgery with an eight day history of a constant bilateral frontal headache, photosensitivity, nausea, vomiting, decreased appetite, variable body aches, fever, and a recent six pound weight loss. Upon questioning, the patient reported that she had been in Arizona for a two week period, approximately two months earlier. On physical examination, her temperature was 100.4F. The rest of the examination was unremarkable.

A CT scan of the head showed cerebral atrophy consistent with age. On spinal tap, the opening pressure was 107mm of water and the fluid showed a pleocytosis of approximately 305 cells, with 42 segs, 50 lymphs, three monos, two eosinophils, and six histiocytes. The CSF glucose was 15mg/dl, protein 134mg/dl, chloride 115meq/liter. Counter immunoelectrophoresis for H. influenza, pneumococcus, and Neisseria meningitidis were negative. VDRL and gram stain, india ink, and cryptococcal antigen tests were also negative. Her chest Xray was normal. Serial lumbar punctures were performed during the patient's hospital course, all of which were similar to the first LP. A PPD was positive (she had been positive for PPD in the past), and the patient received antibiotics and later, triple therapy with isoniazid ethambutol and rifampin. The serum compliment fixation test for coccidioidomycosis was reported positive at a 1:16 titer, but CSF titers were negative. The patient later developed neurological symptoms and signs of paraplegia. Myelogram revealed no evidence of cord compression.

The patient developed evidence of pulmonary embolism and was started on heparin therapy. Five weeks after admission, her condition further deteriorated and she was intubated. Two days later, the seventh spinal fluid (which had been drawn 10 days before) grew out two colonies of coccidioidomycosis immitis. A repeat CT scan demonstrated multiple embolic infarctions in the bitemporal, caudate, and brain stem areas. Amphotericin B therapy was offered but refused by the patient's relatives, and the patient expired six weeks after admission.

On autopsy, the upper segment of the left lower lobe showed a focus of bronchopneumonia with abscess formation, which grew out coccidioidomycosis. The meninges were turbid and had many yellow-grey nodules 0.3-0.2cm in diameter. The brain was diffusely inflamed with multiple micro abscesses and granulomas. Coccidioides immitis spherules were present in abundance; some showed multiple endospores. Similar findings were also noted in the spinal cord tissue. A diffuse vasculitis was also noted.

Discussion

Coccidioides immitis is a free-living saprophytic mycelium that, after a rain, produces spores which are responsible for the infection. These are inhaled and produce spherules in living tissues. Most victims of the disease manifest only a subclinical pulmonary infection which is usually self-limited. In about .05% of the 50,000-100,000 annual symptomatic cases, the disease disseminates.[2] The spread may

occur in bones, joints, skin, viscera, brain, and meninges. Dissemination usually occurs within weeks or months of infection, but the latent period may extend for years. Meningeal involvement occurs in approximately half of all patients with disseminated coccidioidomycosis. Our patient visited Arizona for a two week period, two months prior to the development of clinical symptoms. She was receiving progestational therapy at that time, but had no evidence of residual breast cancer at autopsy. Whether the progestational agents predisposed the patient to the development of disseminated coccidioidomycosis is purely speculative. She had a positive response to the PPD, indicating that her cellular immunity was not totally suppressed.

Patients with meningeal involvement may present with a picture of acute, subacute, or chronic meningitis. Headache is one of the most common symptoms on presentation. Constitutional symptoms, such as weight loss and low-grade fever, mental status changes, and neurological findings, as seen in our patient, are present in nearly one half of the individuals with disseminated fungal infection. Less than a third of the patients show nuchal rigidity or other symptoms and signs of meningeal irritation.[3]

The diagnosis of meningeal involvement is often delayed and in a study by Caudill, the diagnosis was delayed from one to 16 months (mean of seven months). This is because the presenting symptoms and the physical examination were not diagnostically helpful.[4]

The diagnosis of coccidioidal meningitis depends on laboratory evidence of the disease. The typical CSF findings are pleocytosis with lymphocyte predominance, low glucose, and elevated protein.[3] These findings were present in our patient, but could have occurred due to a variety of other meningitides. Ventricular fluid may be diagnostically misleading, and it is not suitable to rule out the diagnosis, or assess the disease status.[17,18] A complement fixation test which detects IgG antibody is positive in only 9% of ill patients in the first week of the disease. There is a good correlation between the level of complement fixing antibody titer and the prognosis.[14-16] Presence of CF antibody in CSF is diagnostic for coccidioidal meningitis.[5,6]

The precipitin test which detects IgM antibody is positive in 53% of symptomatic patients in the first week of illness, and in 91% by the third week.[13,15]

Review of the literature demonstrates that culture of coccidia from the CSF may be extremely difficult.[4, 7-10]

The radiological findings of coccidioidal disease may include an abnormal chest x-ray showing widely distributed infiltrates.[3] At present, CT scan is the most reliable method, demonstrating complications which may occur in the CNS. Hydrocephalus and intraventricular hemorrhage are common.

Skin testing is of limited diagnostic value, since 60% of the asymptomatic people in endemic areas have positive skin tests for coccidiodin.[5]

Amphotericin B is the only drug proven effective in the treatment of coccidioidal meningitis. Unfortunately, intravenous amphotericin B is not effective. Patients must receive intrathecal, as well as intravenous dosages of this drug.[9] Intrathecal amphotericin can be given by lumbar, cisternal, intraventricular, and lateral cervical routes. Surgical implantation of prosthetic reservoirs have also been used. All of these routes may be associated with complications.

Relapse after suspension of therapy is not uncommon.[19,24] Some authorities recommend life-long therapy.[4] All patients should be followed with periodic examination, and lumbar CSF examination every three months for up to two years after the suspension of intrathecal medication.[23,25] Demonstration of C immitis or increases in complement fixation titers denote relapse.[22,23] Miconazole, by intravenous or intrathecal route, has been used in patients refractory to amphotericin B chemotherapy.[12]

Prior to the use of amphotericin B, coccidioidal meningitis had a mortality rate of 100%.[25] With the use of intrathecal and intravenous amphotericin B, the mortality rate is now reported to be 50% in one[4] and 70% in other series.[22,23]

Summary

This 73 year old white female with a history of breast cancer presented with symptoms and signs of meningitis. After an extensive investigation, the diagnosis of coccidioidal meningitis was made. We are presenting this patient to remind physicians in non-endemic areas that this disease may appear in any part of the country. A history of travel to an endemic area with findings of low CSF glucose and elevated protein should arouse suspicion of coccidioidal involvement.

References

A complete list of references for "Coccidioidal Meningitis in an Unusual Geographic Location," may be obtained by writing the *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago IL 60602.

Eleanor Rabin, M.D., is a board certified pathologist affiliated with Evanston Hospital. Dr. Rabin is a member of the Chicago Pathology Society and the American Society of Clinical Pathologists. She was an associate professor at the Moscow Medical and Dental School, department of pathology, 1974-79 and chief, department of histology and cytochemistry-Psychiatric Hospital #1, Moscow, prior to that appointment.

Francis V. Cook, M.D., is a board certified internist with subspecialty certification in infectious diseases affiliated with Evanston and Glenbrook hospitals in Evanston and Glenview. A member of the infectious diseases/hypersensitivity section, Northwestern University and an assistant professor of clinical medicine at the Northwestern University Medical School, Dr. Cook is a member of the American College of Physicians, the American Society for Microbiology and the Infectious Disease Society of America.

Janardan D. Khandekar, M.D., is an associate professor of medicine and associate chief of medical oncology, Northwestern University Medical School. The head of the division of medical oncology and associate director of the Kellogg Community Cancer Care Center, Evanston Hospital, Dr. Khandekar is a diplomate of the American Board of Internal Medicine with subspecialty certification in medical oncology. He is a fellow of the American College of Physicians and highly active in cancer research.

Larry S. Miller, M.D., was a resident physician in the department of medicine, Evanston Hospital, at this writing. A 1981 graduate of the Chicago Medical School, Dr. Miller is a member of the American College of Physicians specializing in internal medicine.

Malpractice Problem Worsening

The blue ribbon task force appointed by Gov. James R. Thompson to study the current malpractice crisis heard firsthand from the state's major insurers of the rapidly deteriorating malpractice situation.

The problem's seriousness was reflected by representatives from one carrier who used their February 7 appearance before the task force as the forum to announce that the company would no longer underwrite malpractice policies in excess of $200,000 per incident for Illinois physicians.

At a subsequent meeting of the Task Force, representatives of the Illinois State Medical Society and Illinois Hospital Association described the seriousness of the situation from their members' perspectives and offered suggestions for solutions.

The carrier announcing the policy limit cutback was The Medical Protective Company of Fort Wayne, Indiana. The carrier formerly wrote coverage of up to $1 million per incident with a $1 million annual aggregate. It now will offer only a $600,000 aggregate limit.

Later, it was learned that the carrier for the American College of Obstetricians and Gynecologists will reduce its coverage offering to $500,000 per incident with a $1 million aggregate. Furthermore, that carrier has placed a moratorium on accepting new policyholders.

Medical Protective

Michael S. Mullen, executive vice president of Medical Protective, told the task force that the malpractice situation was "deteriorating at such a rapid pace that the only answer is legislation." He added that the situation was "not an insurance problem, but a social one."

Mullen and David L. Murray, vice president of Medical Protective, said the carrier's decision to limit its policy offering apparently was due to the instability of the market and the "long tail" on reporting and settling malpractice claims. Medical Protective writes only "occurrence" policies which means it is responsible for all claims originating in a particular policy year, no matter when those claims are reported.

A long tail coupled with an unstable claim experience makes pricing occurrence policies extremely difficult, the company's representatives said. "You don't find out what the price of your product should be until several years after you sell it," Murray said.

Mullen urged the task force to recommend a three-pronged legislative solution to the Illinois General Assembly:

- An absolute cap on damage awards analagous to that for workers compensation;
- A more reasonable statute of limitations; and
- Some sort of screening panel to review claims early in the litigation process.

That approach was the key to a successful resolution of the malpractice problem in Medical Protective's home state of Indiana, according to Mullen.

ISMIE

The task force also heard testimony from Dr.Allan L. Goslin, representing the Illinois State Medical Inter-Insurance Exchange. Dr. Goslin, who is chairman of the Exchange's Investment Committee and a member of its Board of Governors, said the current crisis was due to the large number of frivolous claims, rapidly escalating damage awards in legitimate cases, and the high cost of defending claims.

To support his argument, Dr. Goslin cited several statistics:

- Between 1976 and the end of 1983, the number of Exchange policyholders increased by 12%. During the same period claims were up 167% overall and 186% in Cook County. The average indemnity paid by the Exchange jumped from $20,000 in 1977 to $132,000 in 1983.
- During the same time period, 80% of the claims closed by the Exchange have involved no payment of damages. Of those cases ultimately resolved by a trial, the physician defendant has won 74%.
- By the end of 1984, the Exchange had paid more than $11.1 million in defense costs. Defense costs per claim were about $6,500.

Dr. Goslin told the task force that the Exchange's philosophy was "to settle promptly the claims that have merit but defend vigorously those that don't." He said the Exchange was "committed to the Illinois mar-

ketplace," adding, "we're not here to make a profit, we're here to maintain the availability of insurance for Illinois physicians."

St. Paul

The task force also heard from representatives of the St. Paul Fire and Marine Insurance Company. Tim Morse, senior marketing official for St. Paul's medical services division, informed the task force that the company was experiencing a "sharp upturn" in both claim frequency and severity. However, "claim activity does not necessarily indicate poor medical practice," Morse said. He cited several factors contributing to the problem: (1) An expectation on the part of the public that the medical system can "do everything" for patients; (2) A more than ten-fold increase in the number of million-dollar jury verdicts in a seven-year period; (3) An erosion of the personalized nature of medical care due to increasing group practice arrangements; and (4) Improved technology which now permits treatment of "marginal" cases.

Morse emphasized that the unstable claims climate has made pricing of malpractice insurance a difficult task for insurers. St. Paul's response has been to offer only claims made coverage which covers policyholders for suits filed during the year the policy is in effect. To protect themselves against suits filed later, physicians leaving St. Paul must purchase "reporting endorsement" coverage, according to Morse.

ISMS

At a February 21 meeting of the Task Force, Dr. Robert C. Hamilton, president of the Illinois State Medical Society, outlined a history of the malpractice problem. Dr. Hamilton said total premiums paid for malpractice coverage and the cost of defensive medicine were adding more than $1 billion to the state's health care bill. "That money is being collected for medical care but is not going for delivery of that care," he said, adding, "it's totally unproductive."

The ISMS president laid the blame for the malpractice problem on three factors: (1) Even the best doctors sometimes make mistakes which cause injury to a patient; (2) Patient expectations about what the medical profession can do have been elevated tremendously due to technological advances; and (3) There has been an explosion in the overall incidence of civil litigation.

Dr. Hamilton conceded that there was "no question" that bad doctors and malpractice exist, but not on the scale demonstrated by the number and severity of malpractice suits.

"We're proud of what we've done to clean up our own act," he said. As evidence, he cited the Society's support of amendments to the Medical Practice Act which require the reporting of disciplinary actions against physicians taken by hospitals, medical societies or other professional entities to the state's Medical Disciplinary Board. Malpractice suit settlements also must be reported.

Also cited by Dr. Hamilton were ISMS-sponsored loss prevention programs to help physicians improve their practice techniques and minimize their malpractice risks. Other ISMS and physician activities include efforts to keep abreast of new developments through continuing medical education programs, peer review activities, and specialty society recertification requirements.

In presenting the Society's recommendations for legislation, Dr. Hamilton stressed that "there is nothing in what we want to do that would deny a person his day in court. We truly don't want to deny a true victim of malpractice just and reasonable compensation," he said.

Dr. Hamilton outlined the society's proposals which include:

- Pre-trial screening panels composed of a lawyer, physician and judge to review the merits of malpractice claims before they reach the courtroom.
- Collateral source deductions which would allow jury awards to be reduced by the full amount that an injured party receives from other benefit sources such as medical insurance and workers compensation.
- Patient award guarantees which would make sure injured parties receive the bulk of a malpractice award by setting a sliding scale limit on attorney contingent fees.
- Structured payments which would allow large awards to be paid in installments rather than a lump sum.
- Itemization of awards which would require juries to list all components of awards (*e.g.*, medical care, lost wages, future earnings) to discourage over-compensation.
- Limitations on non-economic awards which would prohibit payments over $100,000 for such things as pain and suffering and loss of consortium.
- Elimination of punitive damages which are often unrelated to any real loss, since a better disciplinary mechanism exists through the Medical Disciplinary Board and if necessary, criminal courts.
- Standards for expert witnesses which would require some familiarity with the specialty and local standards of care involved.
- Early dismissal of uninvolved physicians by means of an affidavit.
- Establishment of liability for untrue allegations which would allow a physician to recoup legal fees and court costs if an attorney or the patient files claims without reasonable cause.
- Elimination of the requirement to prove "special damages" in a legal counteraction for malicious prosecution to make it easier for physicians victimized by frivolous suits to countersue.
- Re-establishment of a limit on economic loss in wrongful death cases which would limit recovery to $25,000 unless a plaintiff can prove a loss in excess of that figure.

IHA

Ira H. Goldberg, administrator of Gottlieb Memorial Hospital in Melrose Park, who is chairman of the Illinois Hospital Association's

Task Force on Tort Reform, told the task force that hospitals are finding reinsurance for excess policy limits much more expensive and are concerned that such coverage might become unavailable.

"Several large domestic companies have withdrawn from the market," Goldberg said. "The availability of domestic companies willing to write excess coverage for hospitals has dropped from approximately 30 companies to only five or six," he said.

"While the frequency of claims may have increased and poses a problem from a loss standpoint," Goldberg said, "such increase in the number of paid claims is manageable. It is the increasing severity of awards that has created the crisis for health care providers."

He explained that when the Illinois Provider Trust was organized by IHA to help hospitals pool their risks, there were no malpractice awards of more than $1 million outside of Chicago and Cook County. "Now the settlements and verdicts downstate in excess of $1 million are almost becoming commonplace," he said. In fact, Goldberg added, the largest verdict known in Illinois was by a jury in Ottawa, Illinois which awarded $10.8 million.

"The 19-members of the Illinois Provider Trust collectively deliver 10,000 babies a year," Goldberg said. "If out of those 10,000 deliveries there is just one brain damaged newborn claim per year involving a settlement in the area of $5 million, the average cost for each delivery just to pay that one claim would be $500 per delivery."

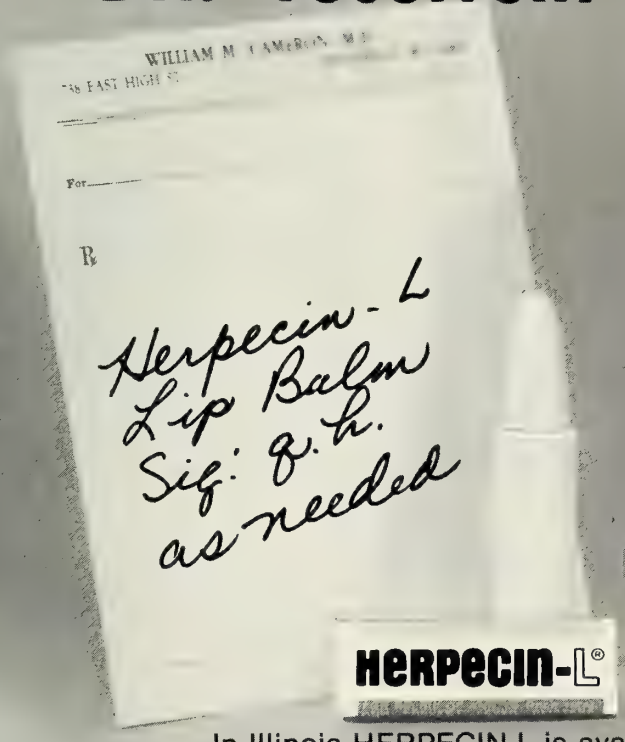
Goldberg offered several solutions from the hospital's viewpoint, including early dismissal from a case when there is no involvement by the physician or hospital, standards for expert witnesses, a reduced statute of limitations for minors, and structured settlements.

Goldberg also told task force members that hospitals should not be held liable for the negligent acts of physicians. "We are concerned with the increasing tendency to impose corporate responsibility on the part of the hospitals for alleged acts of negligence in the practice of medicine by the medical staff physician," he said. "A hospital does not have either the opportunity or the expertise to concurrently judge the quality of care being provided by their physicians. This is basically a responsibility of the medical staff itself. To impose liability on the part of the hospital except in the obvious case where it has permitted an incompetent physician to practice, imposes a legal responsibility that is not related to present practice," Goldberg said.

Task Force Recommendations Expected

The Task Force has been meeting weekly since January 3 to hear from various groups and individuals concerned about the malpractice problem. The Task Force is expected to develop recommendations for remedial legislation and present a final report to the governor by the end of March. ◀

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In Illinois HERPECIN-L is available at all *Medicare-Glaser, Osco, Peoples, Perry, Revco, SupeRx Drug Stores* and other select pharmacies.

Talk To Those Who Can Make A Difference

Lately, physicians have spent a great deal of time talking about the malpractice problem. They've discussed it at length with their colleagues, office staffs and even patients. Some have contacted members of the news media.

Now the time has come to speak directly with those who can make a difference—the representatives and senators who comprise the Illinois General Assembly.

With the legislature back in session, legislators know they will be facing key decisions regarding malpractice reform legislation. The Illinois State Medical Society again will present a package of bills. The Governor's blue ribbon task force that has been investigating the problem also is expected to be offering recommendations. And some legislators—recognizing the seriousness of the current problem—will offer their own proposals.

Now, it's *your* turn. It's up to you to let your legislator know—in your own words—how the current situation is affecting you, your practice, your hospital, your patients, and your community in general.

As part of its Professional Liability Initiative, ISMS has supplied every member with an informational kit that explains the extent of the malpractice problem. "Action teams" are being organized to coordinate efforts at the county medical society and individual hospital levels.

If you cannot identify your legislators or legislative district, please contact the ISMS Governmental Affairs Division at (312) 782-1654 or 800/782-4767 outside the 312 calling area. Also, to help the ISMS lobbying staff's efforts, ISMS would appreciate receiving copies of letters to legislators and any replies you may receive. Please send them to Jeffrey M. Holden, assistant administrator, governmental affairs, Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago IL 60602.

A reference list of state representatives and senators by legislative district is reproduced on the next few pages. Letters to them should be addressed as follows:

State Senator
Honorable _____
State Senate
State House
Springfield, IL 62706

Dear Sen. _____:

State Representative
Honorable _____
House of Representatives
State House
Springfield, IL 62706

Dear Rep. _____,

Telephone calls to senators and representatives can be made via the main Capitol switchboard at (217) 782-2000.

Contact your legislators *today.* Ask your families, colleagues, friends, and patients to do the same. ◀

1st Legislative District
Senator Howard Carroll (D-Chicago)
1st Representative District
Representative Alan J. Greiman (D-Skokie)
2nd Representative District
Representative William J. Laurino (D-Chicago)

2nd Legislative District
Senator Arthur L. Berman (D-Chicago)
3rd Representative District
Representative Lee Preston (D-Chicago)
4th Representative District
Representative Woody Bowman (D-Evanston)

3rd Legislative District
Senator William J. Marovitz (D-Chicago)
5th Representative District
Representative Ellis B. Levin (D-Chicago)
6th Representative District
Representative Bruce A. Farley (D-Chicago)

4th Legislative District
Senator Dawn Clark Netsch (D-Chicago)
7th Representative District
Representative John Cullerton (D-Chicago)
8th Representative District
Representative Jesse White (D-Chicago)

5th Legislative District
Senator Edward Nedza (D-Chicago)
9th Representative District
Representative Joseph Berrios (D-Chicago)
10th Representative District
Representative Myron Kulas (D-Chicago)

6th Legislative District
Senator Thaddeus Lechowicz (D-Chicago)
11th Representative District
Representative Steven G. Nash (D-Chicago)
12th Representative District
Representative Alfred G. Ronan (D-Chicago)

7th Legislative District
Senator Walter W. Dudycz (R-Chicago)
13th Representative District
Representative Ralph Capparelli (D-Chicago)
14th Representative District
Representative Roger McAuliffe (R-Chicago)

8th Legislative District
Senator Philip J. Rock (D-Oak Park)
15th Representative District
Representative Robert LeFlore (D-Chicago)
16th Representative District
Representative James A. DeLeo (D-Chicago)

9th Legislative District
Senator Earlean Collins (D-Oak Park)
17th Representative District
Representative Anthony L. Young (D-Chicago)
18th Representative District
Representative Arthur L. Turner (D-Chicago)

10th Legislative District
Senator John A. D'Arco (D-Chicago)
19th Representative District
Representative Douglas Huff (D-Chicago)
20th Representative District
Representative Juan M. Soliz (D-Chicago)

11th Legislative District
Senator Timothy Degnan (D-Chicago)
21st Representative District
Representative John M. Vitek (D-Chicago)
22nd Representative District
Representative Robert T. Krska (D-Chicago)

12th Legislative District
Senator Margaret Smith (D-Chicago)
23rd Representative District
Representative Larry S. Bullock (D-Chicago)
24th Representative District
Representative Jerry Washington (D-Chicago)

13th Legislative District
Senator Richard H. Newhouse (D-Chicago)
25th Representative District
Representative Carol Moseley Braun (D-Chicago)
26th Representative District
Representative Barbara Flynn Currie (D-Chicago)

14th Legislative District
Senator Jeremiah E. Joyce (D-Chicago)
27th Representative District
Representative John J. McNamara (D-Oak Lawn)
28th Representative District
Representative James F. Keane (D-Chicago)

15th Legislative District
Senator Frank Savickas (D-Chicago)
29th Representative District
Representative Andrew J. McGann (D-Chicago)
30th Representative District
Representative Michael J. Madigan (D-Chicago)

16th Legislative District
Senator Charles Chew (D-Chicago)
31st Representative District
Representative Mary E. Flowers (D-Chicago)
32nd Representative District
Representative Ethyl Skyles Alexander (D-Chicago)

17th Legislative District
Senator Emil Jones (D-Chicago)
33rd Representative District
Representative Nelson Rice (D-Chicago)
34th Representative District
Representative William Shaw (D-Chicago)

18th Legislative District
Senator Glenn V. Dawson (D-Chicago)
35th Representative District
Representative Sam Panayotovich (D-Chicago)
36th Representative District
Representative Howard Brookins (D-Chicago)

19th Legislative District
Senator William F. Mahar, Jr. (R-Homewood)
37th Representative District
Representative Loleta Didrickson (R-Flossmoor)
38th Representative District
Representative Jane Barnes (R-Palos Heights)

20th Legislative District
Senator Beverly Fawell (R-Glen Ellyn)
39th Representative District
Representative Ralph Barger (R-Wheaton)
40th Representative District
Representative Gene L. Hoffman (R-Elmhurst)

21st Legislative District
Senator Forest Etheredge (R-Aurora)
41st Representative District
Representative Mary Lou Cowlishaw (R-Naperville)
42nd Representative District
Representative Suzanne L. Deuchler (R-Aurora)

22nd Legislative District
Senator Judy Baar Topinka (R-Berwyn)
43rd Representative District
Representative Jack L. Kubik (R-Forest Park)
44th Representative District
Representative James R. Stange (R-Oak Brook)

23rd Legislative District
Senator James "Pate" Philip (R-Elmhurst)
45th Representative District
Representative Kathleen Wojcik (R-Schaumburg)
46th Representative District
Representative Lee Daniels (R-Elmhurst)

24th Legislative District
Senator LeRoy W. Lemke (D-Chicago)
47th Representative District
Representative John T. O'Connell (D-Western Springs)
48th Representative District
Representative Robert M. Terzich (D-Chicago)

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49th Representative District
Representative Terry R. Parke (R-Hoffman Estates)
50th Representative District
Representative Donald N. Hensel (R-West Chicago)

26th Legislative District
Senator Greg Zito (D-Melrose Park)
51st Representative District
Representative Ted E. Leverenz (D-Maywood)
52nd Representative District
Representative Linda-Jean Williamson (R-Northlake)

27th Legislative District
Senator Virginia B. Macdonald (R-Arlington Heights)
53rd Representative District
Representative David Harris (R-Arlington Heights)
54th Representative District
Representative Bernard E. Pedersen (R-Palatine)

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55th Representative District
Representative Penny Pullen (R-Park Ridge)
56th Representative District
Representative Cal Sutker (D-Skokie)

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57th Representative District
Representative Margaret Parcells (R-Northfield)
58th Representative District
Representative Grace Mary Stern (D-Highland Park)

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60th Representative District
Representative William E. Peterson (R-Buffalo Grove)

31st Legislative District
Senator Adeline Geo-Karis (R-Zion)
61st Representative District
Representative John S. Matijevich (D-Northlake)
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Representative Robert W. Churchill (R-Lake Villa)

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63rd Representative District
Representative Dick Klemm (R-Crystal Lake)
64th Representative District
Representative Ronald A. Wait (R-Belvidere)

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Representative Jill Zwick (R-East Dundee)
66th Representative District
Representative James Kirkland (R-Elgin)

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Representative John Hallock (R-Rockford)
68th Representative District
Representative E.J. "Zeke" Giorgi (D-Rockford)

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69th Representative District
Representative Richard T. "Dick" Mulcahey (D-Durand)
70th Representative District
Representative Myron Olson (R-Dixon)

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71st Representative District
Representative Joel Brunsvold (D-Milan)
72nd Representative District
Representative M. "Bob" DeJaegher (D-Silvis)

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Representative A.T. "Tom" McMaster (R-Dahinda)
74th Representative District
Representative Richard A. Mautino (D-Spring Valley)

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Representative John Countryman (R-DeKalb)

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Representative Frank Giglio (D-Calumet City)
78th Representative District
Representative Terry A. Steczo (D-Posen)

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Representative Robert J. Piel (R-South Holland)
80th Representative District
Representative Robert P. Regan (R-Park Forest South)

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Senator George Ray Hudson (R-Hinsdale)
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Representative Thomas J. McCracken (R-Downers Grove)
82nd Representative District
Representative J. Dennis Hastert (R-Yorkville)

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Representative Fred J. Tuerk (R-Peoria)
94th Representative District
Representative Carl E. Hawkinson (R-Galesburg)

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Senator Laura Kent (R-Quincy)
95th Representative District
Representative Kent Slater (R-Macomb)
96th Representative District
Representative Jeff Mays (R-Quincy)

49th Legislative District
Senator Vince Demuzio (D-Carlinville)
97th Representative District
Representative Tom Ryder (R-Jerseyville)
98th Representative District
Representative Gary Hannig (D-Mt. Olive)

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99th Representative District
Representative Michael D. Curran (D-Springfield)
100th Representative District
Representative Josephine K. Oblinger (R-Auburn)

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101st Representative District
Representative John F. Dunn (D-Decatur)
102nd Representative District
Representative Michael Tate (R-Decatur)

52nd Legislative District
Senator Stanley B. Weaver (R-Urbana)
103rd Representative District
Representative Helen Satterthwaite (D-Urbana)
104th Representative District
Representative Timothy V. Johnson (R-Urbana)

53rd Legislative District
Senator Max Coffey (R-Charleston)
105th Representative District
Representative Harry "Babe" Woodyard (R-Chrisman)
106th Representative District
Representative Michael Weaver (R-Charleston)

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Senator William O'Daniel (D-Mt. Vernon)
107th Representative District
Representative Charles Hartke (D-Teutopolis)
108th Representative District
Representative Larry Hicks (D-Mt. Vernon)

55th Legislative District
Senator Frank Watson (R-Greenville)
109th Representative District
Representative Dwight P. Friedrich (R-Centralia)
110th Representative District
Representative Ron Stephens (R-Caseyville)

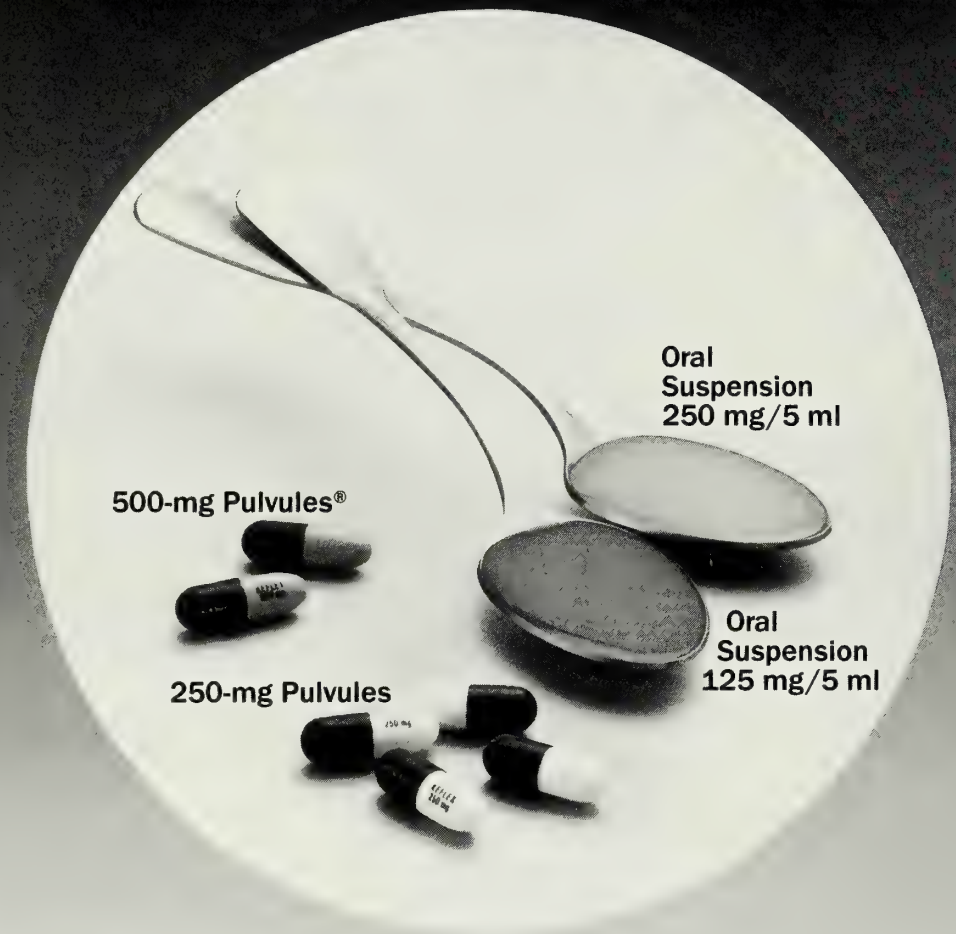
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Senator Sam Vadalabene (D-Edwardsville)
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Convention Handbook

Annual Meeting '85

April 26-28
Chicago Marriott O'Hare Hotel
8535 W. Higgins
(Cumberland & Higgins)
Chicago, Illinois

Members of the House of Delegates
Delegates and Alternate Delegates to the Illinois State Medical Society
Officers of County Medical Societies
Program Summary By Days
Agenda of the House of Delegates
ISMS Delegation to the American Medical Association
Committees of the House of Delegates
Resolutions
ISMS Auxiliary Convention Program

CALLS WILL REACH YOU EASILY AT CONVENTION '85

Doctor, please inform your staff that while you are attending the ISMS annual meeting, you may be reached through the ISMS Physician's Message Center from 9 a.m. to 4 p.m. Friday and Saturday and on Sunday until noon at this number:

1-312-693-4444

The Illinois State Medical Society
cordially invites you
to the President's Night Dinner

April 26, 1985

honoring

Robert C. Hamilton, M.D.
President
Illinois State Medical Society

Dinner-Dance

Entertainment by
Georgia Frances Orchestra
&
The Brass Quartet

Tickets $30.00 per person

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Vice Speaker Lawrence L. Hirsch

Trustees

First District	David B. Littman	1987
Second District	Allan L. Goslin	1986
Third District	James H. Andersen	1986
	Richard Blankshain	1985
	Alfred J. Clementi	1987
	Audley F. Connor, Jr.	1986
	Joan E. Cummings	1987
	Harold L. Jensen	1986
	Arthur R. Peterson	1988
	Pedro A. Poma	1986
	Harry A. Springer	1986
	Cyril C. Wiggishoff	1987
Fourth District	George H. Burke	1985
Fifth District	Robert L. Prentice	1985
Sixth District	George T. Wilkins, Jr.	1987
Seventh District	Boyd E. McCracken	1985
Eighth District	Arthur R. Traugott	1985
Ninth District	Warren D. Tuttle	1987
Tenth District	Thomas P. Meirink	1987
Eleventh District	Raymond A. Dieter, Jr.	1986
Twelfth District	Raymond E. Hoffmann	1986

Trustee-At-Large Robert P. Johnson
AMA Delegation Chairman, *Ex-Officio* Morgan M. Meyer
ISMIE Board of Governors Chairman, *Ex-Officio* Fred Z. White
Chairman of the Board Alfred J. Clementi

Members of the House who have the privilege of the floor without the right to vote in this capacity

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J. Ernest Breed*	1971	Caesar Portes*	1967
Herschel Browns*	1981	Jacob E. Reisch, Honorary*	1979
Edward W. Cannady*	1970	Willard C. Scrivner*	1974
Newton DuPuy*	1968	P. John Seward*	1980
David S. Fox*	1979	Joseph H. Skom*	1977
H. Close Hesseltine*	1961	Leo P. A. Sweeney*	1953
J. M. Ingalls	1976	Philip G. Thomsen*	1969
C. J. Jannings, III	1972	Fred Z. White*	1982
Frank J. Jirka, Jr.*	1973	Cyril C. Wiggishoff*	1983
Robert P. Johnson	1984	George T. Wilkins, Jr.	1978
Fredric D. Lake*	1975		
Burtis E. Montgomery*	1966		

**Also a past trustee or councelor*

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Audley F. Connor, Jr.	Morgan M. Meyer	Arthur R. Traugott
David S. Fox	Michael Nieder	Fred Z. White
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Robert T. Fox	Third District	Joseph Perez	Twelfth District
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Henrietta Herbolsheimer	Third District	John J. Ring	First District
Eugene Hoban	Third District	Richard Rovner	Third District
Ross Hutchison	Eleventh District	Joseph Sherrick	Third District
Kenneth A. Hurst	Eleventh District	George Shropshear	Third District
Eugene P. Johnson	Eighth District	Darrell H. Trumpe	Fifth District
James Laidlaw	Eighth District	Frederick E. Weiss	Third District
Harold Lasky	Third District	Charles K. Wells	Ninth District
Ted LeBoy	Third District	Herman Wing	Third District

Delegates and Alternate Delegates to the Illinois State Medical Society

Downstate Delegates

	County	*Delegates*	*Alternate Delegates*
District #1	Kane (4)	A. Beaumont Johnson	Robert M. Flanigan
		Wayne N. Leimbach	James C. Pritchard
		Francis A. Oslay	William T. Sheehy
		George J. Shimkus	
	Lake (6)	Albino T. Bismonte	George I. Goldstein
		Richard K. Hawkins	Raza M. Khan
		Allan B. Minster	Phyllis S. Loeff
		Eugene Pitts	Luis Planas
		Peter L. Vinciguerra	Manoochehr Sharifi
		Julius J. Wineberg	Robert D. Wasson
	McHenry	August M. Rossetti	William Larsen
District #2	Bureau		Louis Paul Lukancic
	Ford	Ross N. Hutchison	Dzi Van Vu
	Iroquois	R. Kent Swedlund	Leslie C. Duis
	Kankakee	Donald Parkhurst	James Geist
	Kendall		John P. Cullinan
	LaSalle	Edward J. Fesco	Richard A. Schmidt
	Livingston	Homer Parkhill	George Chen
	Marshall-Putnam	Don Gallagher	Joe W. Cannon
	Will-Grundy (4)	Van L. Hicks	Kenneth P. Jesunas
		Theodore M. Kanellakes	Mushtaq Ahmad Khan
		Albert W. Ray, Jr.	Mark R. Sinibaldi
		Stanley G. Rousonelos	William D. Woodward
	Woodford	Michael M. McNett	Hans W. Riggert
District #4	Fulton	Jamie H. Cercone	Jai Chul Cha
	Hancock	Charles F. Eddingfield	James E. Coeur
	Henderson	Silvino C. Lindo, Jr.	
	Henry-Stark	Reinert N. Svendsen, Jr.	James C. Parsons
	Knox	Jerry Ramunis	Agha Babanoury
	McDonough	Kenneth Pawlias	Burdis Andernovics
	Mercer		Mohamed I. Rajput
	Peoria (6)	Lorris M. Bowers	Richard H. Lee
		Chester Danehower, Jr.	Tim C. Miller
		James R. DeBord	Gerald Palagallo
		Paul M. Norris	Richard J. Popp
		Rodney C. Osborn	John J. Taraska
		Lorin D. Whittaker, Jr.	David E. Trachtenbarg
	Rock Island (3)	Michael C. Ferdinands	James Bull
		Manuel O. Guerrero	Ronald Frus
		Thomas Stoffel	J.H. Gardner
	Schuyler	Robert E. Cox	Henry C. Zingher
	Tazewell	Robert M. Wright	Robert L. Tucker
	Warren	Chainaronk Limanon	John K. Alukal

Delegates and Alternate Delegates—Downstate

	County	*Delegates*	*Alternate Delegates*
District #5	DeWitt	John W. Veirs	Robert E. Myers
	Logan	Edward Ulrich	James Borgerson
	McLean (2)	Robert M. Reardon	Robert E. Knight
		Wilbert G. Thielemann	Kent Taulbee
	Mason	Jack Means	John W. McHarry, Jr.
	Montgomery	Calixto Aquino	William Douglas
	Sangamon (5)	Mir-Twofig Arjmand	Donald R. Graham
		William Curtis	John M. Holland
		Edward G. Ference	Jane Jackman
		Michael C. Snyder	Stephen P. Stone
		Elvin G. Zook	
District #6	Adams	Frank H. Chamberlin	James Sutherland
	Greene	Jose Parcon	Gary L. Turpin
	Jersey-Calhoun	Edgar N. Gipson	Abbas Assar
	Macoupin	Robert G. England	John Ubben
	Madison (3)	E. K. DuVivier	Norbert T. Belz
		Melvin J. Freedman	Rosalyn B. Lepley
		Sadiq Mohyuddin	Edward F. Ragsdale
	Morgan-Scott	Joseph D. Winterhalter	James W. Veenstra
	Pike	Carlos B. Lara	Ronald L. Johnson
District #7	Bond	Marion K. Kaufmann	Boyd E. McCracken
	Christian	M. T. Salaymeh	E. Doyle Slifer
	Clinton	Richard L. Dermody	Belen E. Floreza
	Effingham	Ruben Boyajian	
	Fayette	Vasudev Kachgal	Donald H. Rames
	Macon (2)	Charles Downing	Howard Penning
		Dale Sunderland	Merle J. Schrodt
	Marion	Thomas E. Wood	Palaniappan Suppiah
	Moultrie	Eugene J. Boros	Phillip H. Best
	Piatt	George G. Green	William E. Mundt
	Shelby	Urbano A. Dauz	Virginia Caballero-Dauz
District #8	Champaign (3)	Harlan J. Failor	Victor F. Feldman
		Lewis Trupin	David W. Morse
		Robert E. Welke	Charles R. Shepardson
	Clark	Steven Macke	Eugene P. Johnson
	Coles-Cumberland	Luke L. Burchard	Joseph B. Mallory
	Crawford	Charles N. Salesman	Dean J. Pelley
	Douglas	Robert N. Arrol	Grant Jones
	Edgar	Jerry M. Ingalls	James H. Acklin
	Lawrence	Gary D. Carr	Larry D. Herron
	Richland	Robert E. Einhorn	Stephen Piercy
	Vermilion	Edward S. Warren	Donald K.J. Rokosch
District #9	Alexander-Pulaski	Crisostomo Lozada	Gemo Y. Wong
	Franklin	Harry L. Lewis	John P. Pope
	Gallatin	John E. Doyle	

Delegates and Alternate Delegates—Downstate

	County	*Delegates*	*Alternate Delegates*
	Jackson	Paul P. Lorenz	Roger Klam
	Jefferson-Hamilton	Charles K. Wells	
	Massac	Enrique T. Yap	Benito C. Bajuyo
	Saline-Pope-Hardin	Larry R. Jones	Alexander Z. Goldstein
	Union	Jerry Goddard	William H. Whiting
	Wabash	William L. Walling	
	Wayne	Eugene B. Loftin	Paul S. Nierenberg
	White	Phillip D. Boren	
	Williamson	George B. Murphy	Robert D. Kane
District #10	Monroe	Edilberto F. Maglasang	Chung H. Khan
	Perry	John Fozard	Carl J. Campanella
	Randolph	O. W. Pflasterer	Allan L. Liefer
	St. Clair (4)	Wallace P. Berkowitz	Charles R. Frazer, Jr.
		Lloyd E. Thompson	Silvana Menendez
		Robert C. Wanless	William A. Simmons
		Ronald G. Welch	Dennis J. Stanczyk
	Washington	Methee Vanadilok	
District #11	DuPage (10)	Peter A. Brusca	Anita Balodis
		James P. Campbell, Jr.	Elias E. Benezra
		Luis E. Cespedes	Robert D. Dooley
		Robert E. Fitzgerald	Willard O. Elyea
		William B. Frymark	Joseph P. McKay
		William P. Gibbons	Sharon J. Pelton
		Morgan M. Meyer	Thomas W. Stach
		Joseph R. O'Donnell	
		Erlo Roth	
		Garth D. Smith	
District #12	Boone	Jon E. Dennis	
	Carroll	Benjamin Sy	Rita H. Rabheru
	DeKalb	John W. Ovitz	Dean A. Miller
	Jo Daviess	Francis B. Waites	James C. Lambros
	Lee	Donald W. Edwards	Jeff Wexler
	Ogle	Don E. Hinderliter	Nancy S. Williams
	Stephenson	Ahmed Rasheed	Young C. Chung
	Whiteside	John Hubbard	Shashikant A. Patel
	Winnebago (5)	Robert L. Bertrand	Robert A. Behmer
		William E. Kobler	Fredrick C. Kullberg
		Joseph B. Perez	John T. Leonard
		Forrest H. Riordan, III	Warren L. Lowry
		Jerome S. Weiskopf	Daniel L. Swift
Medical Student Section		Karen Kawala	Gail Herman
Resident Physicians Section		Charles Cattano	Linda Brubaker

Cook County Delegates

Delegates	*Alternate Delegates*	*Delegates*	*Alternate Delegates*
Aaronson, Donald W.	Al-Aswad, Basel	Marshall, Wm. J.	Montero, Jose R.
Ahstrom, James P. Jr.	Aranha, Gerard V.	Mason, John W.	Moutvic, Richard G.
Andelman, Samuel L.	Araujc, Julius C.	McDadc, Wm.	Mowatt, Oswald
Armstrong, Claresa M.		Mostowfi, Kiumars	Munoz, Maria I.
Beck, Charles A.	Baldoza, Maximo B.	Muriel, Hugo H.	Murphy, Danl. J.
Beinar, Peter J.	Becker, Frank O.	Murray, Meredith B., Jr.	Murphy, Jos. L.
Bellows, Randall T.	Bekerman, Carlos		
Beranek, George B.	Bianchin, James T.	Nemecek, Raymond W.	Neumann, Helene
Berg, Max	Bielski, Steven J.	Neskodny, Jaroslav F.	Nikurs, Lydia
Bogen, Gilbert	Blair, Kenneth M.		
Brant, Julius	Brill, Norman R.	O'Sullivan, Donal D.	O'Donoghue, Michael
Brislen, Andrew J.	Brottman, Michael D.	Okner, Henry B.	Olson, James C.
Burdick, Allison L., Jr.	Byrne, Mitchel P.	Olen, Richard N.	
Burke, Edward A.		Olivar, Adriano S.	Palmer, Arthur S.
Burkhead, Howard C.	Casey Donald E., Jr.	Ostrowski, Fabian S.	Panayotou, Irene
	Chavez, Ariel R.		Pantone, Anton M.
Carroll, Catherine G.	Christensen, Eldis M.	Pamintuan, Rodolfo L.	Pardo, Yrech
Casey, Gerald M.	Compall, Theodore C.	Pedroso, Aldo F.	Patel, Jashbhai M.
Cermak, Miles	Cucco, Ulisse P.	Perritt, Richard A.	Perlman, Jack M.
Chaljub, Najib	Curl, Geo. G.	Petty, David T.	Prinz, Richard A.
Ciskoski, Ronald J.		Pochyly, Donald F.	Pruc, Jeremias N.
Coleman, John M.	De Leon, Lilia S.		
Costanzo, Vincent A., Jr.	Del Fava, Raymond L.	Quinlan, Donald	Ray, Biswamay
Cummings, Joan E.	Di Marco, Eugene R.		Reinstein, Michael
		Rice, Clair M. Jr.	Renga, Dominick S.
Danckers, Ulrich F.	Earles, Lucius C.	Romanus, Raymond J.	Richardson, James M.
Diaz, Alfonso		Rothstein, David A.	Rodrigues, Roger L.
Diffenbaugh, Willis G.	Fabian, Sydney	Ruzich, Stanley E.	Rodriguez, Alberto E.
Dohrmann, George J.	Filipowicz, Roman I.		Roman, Alan M.
	Forkosh, David S.	Saulys, Augusta Z.	Rubio, Nunilo
Falloon, Edwin	Friedell, Peter E.	Schifano, Joseph	
Fischer, Arthur R.		Schimel, Samuel	Saltiel, Isaac
Fish, Wm. D.	Geline, Richard A.	Schuetz, John N.	Santhanam, S.
Fitzgibbons, James P.	Gianasi, Chas A.	Seed, Randolph W.	Sassetti, Richard J.
Flanagan, Chas L.	Gnade, Gerard R.	Shapiro, Maynard I.	Saulys, Vacys
Frankel, Jerome J.	Gogan, Wm. T.	Short, Marshall H.	Schall, Saml. M.
Fredrick, Earl E.	Gorday, Rose L.	Simon, Arnold	Schmidt, Jonathan L.
Friedell, Morris T.	Goyal, Arvind K.	Sinaiko, Edwin S.	Schwartz, Malcolm
	Graudins, Gunars	Soboroff, Burton J.	Senno, Aref
Gertz, Geo. J.		Solon, Earl N.	Shima, Arthur T.
Goodman, Harold	Hirschmann, Richard A.	Sprang, M. Leroy	Shobris, Martin
Green, Martin W.		Staley, Warren H.	Siedentop, Karl H.
Gueyikian, Berj	Ignatoff, Jeffrey M.	Stephens, Natalie	Silverstein, Gerald
		Suckow, Earl E.	Smith, William S.
Harwood, Thomas R.	Johnson, M. Anita	Sugar, Sam J.	Souman, Mouhammad
Herman, Gail D.	Jones, Richard J.		Stevenson, George F.
Hinkamp, Jos. F.		Tansey, William J.	Stockhammer, Dan
Hoban, Eugene T.	Kalsch, Harry E.	Tekdogan, Mehmet M.	Strohl, Lee H.
Hoeltgen, Maurice M.	Kirschner, Ronald L.	Tennant, Jeffrey S.	Study, Robt. S.
Hyde, John S.	Kowal, Roland A.	Terek, Richard M.	Sultan, Thomas R.
		Thampy, Kishore J.	Supple, Peggy A.
Iannucci, Thos. M.	Lalmalani, Gopal G.	Thompson, James R.	Sutoris, Edward D.
	Lubben, Georgia D.	Treister, Michael R.	
John, Thomas			Thomas, Andrew L.
Joslyn, Everett	McCabe, Mary J.	Ungar, Jacob	Turow, David D.
	McCarthy, William D.		
Kahn, Sidney C.	Meccia, Donald L.	Vanecko, Robt. M.	Wallk, Silas
Kall, John G.	Meyenberg, John E.	Vega, Jesus G.	Weiss, John W.
Kirschenbaum, M. Barry	Miale, Thomas D.	Velarde, Hugo R.	Wienke, H. Richard
Kniffin, Judith M.	Modi, C. M.		
		Walkowiak, Lydia	Zelinger, Allan B.
Lagorio, Geo. L.		Wehrmacher, Wm. H.	Zitek, Russell W.
Libman, Robert H.		Williams, Jack	
Lobraico, Rocco V., Jr.		Williamson, Gail D.	
Lukaszewski, Edwin J.			
		Zurita, Victor M	
MacNerland, Robt H.			
Malvar, Thomas C.			

1985 Officers of County Medical Societies

County	*Members*	*President*	*Secretary*
Adams	Members: 92-Dist. 6 Maxine Boyer, Ex. Sec., 2039 Sunnybrook, P.O. Box 767, Quincy 62306	Philip C. Wilson 1101 Main, Quincy 62301	Richard L. Newman 1225 Broadway, Quincy 62301
Alexander-Pulaski	Members: 7-Dist. 9	Crisostomo Lozada 529 Cross St., Cairo 62914	Gemo Wong 529 Cross St., Cairo 62914
Bond	Members: 8-Dist. 7	Thomas D. Dawdy Health Care Drive, Greenville 62246	Charles Daisy 308 W. College Greenville 62246
Boone	Members: 27-Dist. 12	Anthony Molinari 119 S. State St., Belvidere 61008	John Steinkamp 824 Van Buren, Belvidere 61008
Bureau	Members: 39-Dist. 2	Paul V. Paul 1302 N. Greenwood, Spring Valley 61362	Rakesh K. Garg 600 E. First, Spring Valley 61362
Carroll	Members: 8-Dist. 12	Cecil G. Piper 203 W. Market, Mt. Carroll 61053	Basilios G. Lambos 202 Main St., Savanna 61074
Champaign	Members: 291-Dist. 8 Larry Booth, Ex. Sec., 1408 W. University, Urbana 61801	Milton Carlson 104 W. Clark, Champaign 61820	Paul W. Yardy Carle Clinic, 602 W. University, Urbana 61801
Christian	Members: 23-Dist. 7	Virgilio Dycoco 217 S. Locust, Pana 62557	I. Del Valle 311 S. Main, Taylorville 62568
Clark	Members: 6-Dist. 8	George T. Mitchell Cork Medical Center, Marshall 62441	Steven Macke Cork Medical Center, Marshall 62441
Clay	Members: 7-Dist. 7	Alva P. Naney, Jr. 433 E. 7th St., Flora 62839	Eugene Foss 115 W. 2nd St., Flora 62839
Clinton	Members: 16-Dist. 7	R. L. Dermody P.O. Box 99, Breese 62230	Jonathan Osborn P.O. Box 99, Breese 62230
Coles-Cumberland	Members: 66-Dist. 8	Robert Hart Link Clinic, 1710 Wabash, Mattoon 61938	Sjanna Johnston Tri County Clinic, 410 W. Third, Casey 62420
Cook	Members: 9745-Dist. 3 Fred Schwartz, Exec. Dir., 515 N. Dearborn St., Chicago 60610	Jere E. Freidheim Mercy Hosp. and Med. Ctr., Stevenson and King Dr., Chicago 60616	Robert M. Vanecko 6200 N. Kilpatrick, Chicago 60946
Crawford	Members: 14-Dist. 8	Michael W. Elliott 1002 N. Allen, Robinson 62454	W.B. Schmidt 408 S. Cross St., Robinson 62454

County	*Members*	*President*	*Secretary*
DeKalb	Members: 60-Dist. 12	William K. Lee 232 S. Second, DeKalb 60115	John D. Wassner 954 W. State, Sycamore 60178
DeWitt	Members: 8-Dist. 5	John W. Veirs 219 E. Main, Clinton 61727	C. N. Radhakrishna 210 E. Main, Clinton 61727
Douglas	Members: 9-Dist. 8	Grant A. Jones 318 S. Ash, Arthur 61911	Robert Arrol 126 S. Locust, Arcola 61910
DuPage	Members: 736-Dist. 11 Lillian Widmer, Ex. Admin., 800 Roosevelt Road, Building B-Suite 300, Glen Ellyn 60137	Erlo Roth 8999 S. Countyline Rd., Hinsdale 60521	James P. Campbell 322 N. Blanchard St., Wheaton 60187
Edgar	Members: 15-Dist. 8	Duane Haskell 502 Shaw, Paris 61944	J. M. Ingalls Medical Center Clinic, Paris 61944
Effingham	Members: 24-Dist. 7	Herbert F. Webb P.O. Box 1268, Effingham 62401	Ruben Boyajian P.O. Box 1139, Effingham 62401
Fayette	Members: 11-Dist. 7	Joshua Weiner 1007 N. Eighth St., Vandalia 62471	Vasudev Kachgal 802 N. Eighth, Vandalia 62471
Ford	Members: 16-Dist. 2	Robert Arthur P.O. Box 527, Gibson City 60926	David J. Hagan 214 N. Sangamon, Gibson City 60926
Franklin	Members: 22-Dist. 9	Yihnan Chiou 406 W. St. Louis St., W. Frankfort 62896	Bob G. Thompson 309 W. St. Louis St., W. Frankfort 62896
Fulton	Members: 41-Dist. 4	John H. Day R.R. 4, Canton 61520	Hassan Alsheik P.O. Box 498, 115 N. Main, Canton 61520
Gallatin	Members: 1-Dist. 9	John E. Doyle Ridgway 62979	John E. Doyle Ridgway 62979
Greene	Members: 6-Dist. 6	Jude A. Caselton 727 South 9th, Carrollton 62016	James C. Reid 712 S. College, Greenfield 62044
Hancock	Members: 9-Dist. 4	Vasant Pawar 216 Parkway Drive, Carthage 62321	James E. Coeur 630 Locust, Carthage 62321
Henderson	Members: 1-Dist. 4	Silvino Lindo, Jr. Box 248, Biggsville 61418	Silvino Lindo, Jr. Box 248, Biggsville 61418
Henry-Stark	Members: 32-Dist. 4	Donald Ford 648 N. Chicago Geneseo 61254	Richard M. Terry 420 S. Chestnut, Kewanee 61443
Iroquois	Members: 22-Dist. 2	A.T. DeVas Gunawardhane 355 E. 6th Ave. Clifton 60927	Dominic Imburgia 618 S. 5th St., Watseka 60970
Jackson	Members: 129-Dist. 9	Brian McElheny 404 W. Main, Carbondale 62901	Clifford L. Coleman 306 W. Main, Carbondale 62901

County	*Members*	*President*	*Secretary*
Jasper	Members: 2-Dist. 8	Juan Jose Serra 507 W. Washington, Newton 62448	Monico Low P.O. Box 377, Newton 62448
Jefferson-Hamilton	Members: 46-Dist. 9	Manoj H. Desai #1 Doctors Park Rd., Mt. Vernon 62864	Kenneth Peart #1 Doctors Park Rd., Mt. Vernon 62864
Jersey-Calhoun	Members: 12-Dist. 6	Robert G. Mindrup 308 S. Washington, Jerseyville 62052	Bernard Baalman Medical Center, Hardin 62047
Jo-Daviess	Members: 9-Dist. 12	David Hockman 219 Summit St., Galena 61036	Francis B. Waites 219 Summit St., Galena 61036
Kane	Members: 325-Dist. 1 H. Michael Wild, Ex. Dir., 355 First St., Batavia 60510	Francis A. Oslay 1705 South St., Geneva 60134	A. Beaumont Johnson 860 Summit St., Elgin 60120
Kankakee	Members: 108-Dist. 2 Joan Moody, Exec. Sec., St. Mary's Hosp., 500 W. Court, Kankakee 60901	Randall L. Mann 400 N. Wall, Kankakee 60901	Charles F. Lind 500 W. Court St., Kankakee 60901
Kendall	Members: 5-Dist. 2	John P. Cullinan Main & VanBuren, Oswego 60543	Joseph L. Daw Main & VanBuren, Oswego 60543
Knox	Members: 85-Dist. 4 Jane Gau, Exec. Sec., 695 N. Kellogg, Galesburg 61401	Richard M. Flacco Bondi Bldg., Galesburg 61401	Robert H. Wagner Grove & Seminary, Galesburg 61401
Lake	Members: 485-Dist. 1 Jane R. Stein, Exec. Dir., 1117 S. Milwaukee, Forum One—Suite 13, Libertyville 60048	Allan B. Minster 135 N. Greenleaf St., Gurnee 60031	Richard C. Gayes 450 W. Highway 22, Barrington 60010
LaSalle	Members: 112-Dist. 2	Caner Celeboglu 104 6th St., Streator 61364	Allan L. Goslin Route 4, Streator 61364
Lawrence	Members: 10-Dist. 8 Mrs. Georgia T. Tabler Executive Secretary Lawrence County Mem. Hosp. West State St. Lawrenceville, IL 62439	Alexander Po R.R. 4, Lawrenceville 62439	Francisco E. Martin 542 N. Main, Bridgeport 62417
Lee	Members: 27-Dist. 12	Osma Al Masri 403 E. First, Dixon 61021	Tiam H. Lie 403 E. First St., Dixon 61021
Livingston	Members: 31-Dist. 2	George Chen R.R. 1, Chenoa 61726	Karl T. Deterding 612 E. Water, #109, Pontiac 61764
Logan	Members: 28-Dist. 5 Judith Gordon, Ex. Sec. Abraham Lincoln Hosp. 311 8th St. Lincoln 62656	Steven D. Kottemann Abraham Lincoln Medical Group, 311 8th St., Lincoln 62656	James Riley Abraham Lincoln Medical Group, 311 8th St., Lincoln 62656
Macon	Members: 167-Dist. 7 Mary J. Bretz, Ex. Sec., 1800 E. Lake Shore Dr., Decatur 62521	H. Gale Zacheis 301 Hay St., Decatur 62526	Robert D. Miller 1210 S. Jasper, Decatur 62521

County	*Members*	*President*	*Secretary*
Macoupin	Members: 20-Dist. 6	John Ubben 428 Caldwell, Staunton 62088	Robert England 1115 Morgan, Carlinville 62626
Madison	Members: 227-Dist. 6	Robert G. Trinity St. Elizabeth Med. Ctr., Granite City 62040	Norman E. Taylor 95 S. 9th St., E. Alton 62024
Marion	Members: 47-Dist. 7	P.T. Durian 938 E. McCord St., Centralia 62801	Mary K. Markle 1201 E. Broadway, Centralia 62801
Marshall-Putnam	Members: 3-Dist. 2	Don Gallagher Granville 61326	Joe W. Cannon 202 South Main, Lacon 61540
Mason	Members: 5-Dist. 5	Henry W. Maxfield 315 E. Chestnut, Mason City 62664	Henry W. Maxfield 315 E. Chestnut, Mason City 62664
Massac	Members: 4-Dist. 9	Enrique T. Yap 510 W. 10th St., Metropolis 62960	Benito Bajuyo Massac Memorial Hosp. Addition, Metropolis 62960
McDonough	Members: 33-Dist. 4	Rick Iverson 505 E. Grant, Macomb 61455	Richard C. Watson 525 E. Grant, Macomb 61455
McHenry	Members: 88-Dist. 1 Evelyn Rosulek, Ex. Sec., 308 E. Kimball, Woodstock 60098	Honeid M. Baxamusa 460 Coventry Ln. Crystal Lake 60014	Basudeb Saha 4318 W. Crystal Lake Road, Apt. 4-F McHenry 60050
McLean	Members: 135-Dist. 5 Madge Williams, Exec. Adm., 1236 E. Empire, Bloomington 61701	John R. Krueger One State Farm Plaza—B-1, Bloomington 61701	Jerry N. Ringer 1008 N. Main St., Bloomington 61701
Mercer	Members: 4-Dist. 4	M.I. Rajput 209 S. College, Aledo 61231	Dennis D. Palmer P.O. Box 142, 409 N.W. Fourth, Aledo 61231
Monroe	Members: 11-Dist. 10	Chung H. Khan P.O. Box 142, Waterloo 62298	William Winkler 650 N. Market, Waterloo 62298
Montgomery	Members: 18-Dist. 5	Dennis Ross Billiter Med. Arts Bldg., 1235 E. Union, Litchfield 62056	Roger Wujek 1225 E. Union, Litchfield 62056
Morgan-Scott	Members: 44-Dist. 6	Cary Andras 2000 W. Morton Rd., Jacksonville 62650	Richard Fox 1600 W. Walnut, Jacksonville 62650
Moultrie	Members: 6-Dist. 7	Phillip Best 14 N. Washington, Sullivan 61951	Dean McLaughlin 2 W. Adams, Sullivan 61951
Ogle	Members: 19-Dist. 12	L. T. Koritz 324 Lincoln, Rochelle 61068	Russell Zack P.O. Box 418, Rochelle 61068
Peoria	Members: 461-Dist. 4 M. John Hanni, Jr., Ex. V.P., 427 Ist Nat'l Bank Bldg., Peoria 61602	Frederick J. Heinzen 1221 W. Glenn, Peoria 61614	Thomas G. Cassidy 515 N.E. Glen Oak Suite 205, Peoria 61603

County	*Members*	*President*	*Secretary*
Perry	Members: 13-Dist. 10	Raghuveer M. Kudva, 900 N. Washington, DuQuoin 62832	John G. Fozard 206 N. Main, Pinckneyville 62274
Piatt	Members: 5-Dist. 7	George Green 1109A N. State, Monticello 61856	Joseph Allman 121 N. State, Monticello 61856
Pike	Members: 9-Dist. 6	Ronald Johnson 121 N. Franklin, Pittsfield 62363	Carlos B. Lara 203 N. Madison, Pittsfield 62363
Randolph	Members: 22-Dist. 10	Meechai Puntumabumrung P.O. Box 168 Red Bud 62278	Robert McKissick 818 E. Broadway, Sparta 62286
Richland	Members: 27-Dist. 8	Don Hatten Weber Medical Clinic, 1200 N. East St., Olney 62450	Jean Miller Weber Medical Clinic, 1200 N. East St., Olney 62450
Rock Island	Members: 221-Dist. 4 James A. Koch, Ex. Sec., 608 Kahl Bldg., 326 W. Third St., Davenport, Iowa 52801	Shashi Upadhya 616 35th Ave., Moline 61265	Stephen Adler 1505 7th St., Moline 61265
St. Clair	Members: 282-Dist. 10 Ed Belz, Ex. Sec., 6400 W. Main, Suite 3L, Belleville 62223	Terrence Klingele 301 W. Lincoln, Suite 203, Belleville 62221	Silvana Menendez 6600 W. Main St., #8, Belleville 62223
Saline-Pope-Hardin	Members: 23-Dist. 9	Samir Abdo 1201 Pine St. Eldorado 62930	Han M. Hanafy 203 N. Vine, Harrisburg 62946
Sangamon	Members: 462-Dist. 5 L. R. Brosi, Ex. Adm., 522 E. Monroe, Room 203, Springfield 62701	Norman J. Scheibling Franklin Life Insurance Co., Springfield 62705	Elvin G. Zook SIU School of Medicine, P.O. Box 3926, Springfield 62708
Schuyler	Members: 4-Dist. 4	R. R. Dohner 103 W. Washington, Rushville 62681	Henry C. Zingher 110 N. Congress, Rushville 62681
Shelby	Members: 10-Dist. 7	P. D. Gurujal Shelby Cty. Med. Cntr., Shelbyville 62565	Otto G. Kauder P.O. Box 225, Shelbyville 62565
Stephenson	Members: 62-Dist. 12	George Lagen Freeport Memorial Hosp., 1045 W. Stephenson St., Freeport 61032	David W. Hanson 1036 W. Stephenson St., Freeport 61032
Tazewell	Members: 62-Dist. 4 Colleen Ingersoll, Exec. Sec., P.O. Box 778, Pekin 61554	Steven G. Clark 1503 Valle Vista, Pekin 61554	Mahboob Sheikh Pekin Memorial Hospital 14th & Court Pekin 61554
Union	Members: 12-Dist. 9	Jerry L. Goddard 517 N. Main, Anna 62906	Carroll O. Loomis Union County Hosp., Main St., Anna 62906
Vermilion	Members: 106-Dist. 8	Jamie L. Gomez 733 N. Logan, Danville 61832	Michael Lomax 723 N. Logan, Danville 61832

County	*Members*	*President*	*Secretary*
Wabash	Members: 6-Dist. 9	Ernest Lowenstein 1123 Chestnut, Mt. Carmel 62863	C. L. Johns 114 W. 5th St., Mt. Carmel 62863
Warren	Members: 16-Dist. 4	Kenneth E. Ambrose 219 E. Euclid, Monmouth 61462	Glenn W. Chamberlin 219 E. Euclid, Monmouth 61462
Washington	Members: 7-Dist. 10	Gary Goforth P.O. Box 307, Nashville 62263	Ralph H. Kelley P.O. Box 307, Nashville 62263
Wayne	Members: 11-Dist. 9	Sigmund W. Konarski 407 E. Center St., Fairfield 62837	Eugene B. Loftin 301 N.W. Eleventh St., Fairfield 62837
White	Members: 7-Dist. 9	Morris A. McCall R.R. 2, Box 132 B, Carmi 62821	David Stricklin 1400 W. Main, Carmi 62821
Whiteside	Members: 55-Dist. 12	Kevin Roache 101 E. Miller Rd., Sterling 61081	Dean Fondahn 101 E. Miller Rd., Sterling 61081
Will-Grundy	Members: 257-Dist. 2 Ronald W. Batozech, Ex. Sec., 3033 W. Jefferson, Suite 220, Joliet 60435	Theodore M. Kanellakes 229 N. Hammes Ave., Joliet 60435	Wayne M. Kassel 2100 Glenwood Ave. Joliet 60435
Williamson	Members: 38-Dist. 9	Timoteo R. Castro, Jr. 120 W. Walnut, Herrin 62948	Herbert V. Fine 110 N. Division, Carterville 62918
Winnebago	Members: 429-Dist. 12 Robert Carlson, Exec. Adm., 630 E. Jefferson, Rockford 61107	William E. Kobler 5670 E. State St., Rockford 61108	Robert H. Pierce 10747 Quail Hill Cove, Rockford 61111
Woodford	Members: 7-Dist. 2	Hans Riggert Metamora 61548	Ron Meyer Roanoke 61561

No Organized County Society: Cass-Brown, Edwards, Johnson, Menard

Joint County Societies: Alexander-Pulaski; Coles-Cumberland; Henry-Stark; Jefferson-Hamilton; Jersey-Calhoun; Marshall-Putnam; Morgan-Scott; Saline-Pope-Hardin; Will Grundy.

The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in the Reference Issue (October). Members who wish to notify the Chairman of the Board of their availability can clip and submit the coupon below.

Name: _____ City: _____ Zip: _____

Address: _____

Telephone: () _____

County Medical Society: _____

Medical specialty and type of practice: _____

Committee in which interested: _____

Expertise for this committee: _____

Send to: Chairman, Board of Trustees, Illinois State Medical Society
Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602

Agenda
1985 House of Delegates

Julian W. Buser, M.D., Speaker/Lawrence L. Hirsch, M.D., Vice-Speaker

First Session

9:30 a.m. ——— Friday, April 26, 1985 ——— Chicago Marriott O'Hare Hotel
Grand Ballroom

1. Call to order
 Julian W. Buser, M.D., Speaker
2. Invocation
3. Report of Credentials Committee
4. Report of Committee on Rules and Order of Business
5. Approval of minutes of previous meeting
6. Memorial Service for members deceased since April, 1984, conducted by Alfred J. Kiessel, M.D., Secretary-Treasurer
7. Introduction of special guests
8. Remarks of special guests
9. Reports of ancillary groups
 Mrs. Vivian Reardon, president, Illinois State Medical Society Auxiliary
 Mrs. Anna Cannon, president, Illinois Society, American Association of Medical Assistants
10. Announcement of team physician awards
11. IMPAC report
 Cyril C. Wiggishoff, M.D., Chairman
12. Introduction of AMA Delegates and Alternate Delegates
 Morgan M. Meyer, M.D., Chairman
13. Report of Chairman, Board of Trustees, Alfred J. Clementi, M.D.
14. Remarks of Speaker
15. Resolutions and supplementary reports
16. New business and announcements
 Delegates' Buffet—11:30a.m.-1:30p.m.
 Reference Committees—1:30 p.m.
17. Recess until 9:30a.m., Saturday, April 27, 1985

Second Session

9:30 a.m. ——— Saturday, April 27, 1985 ——— Chicago Marriott O'Hare Hotel
Grand Ballroom

1. Call to order by the Speaker
2. Report of Credentials Committee
3. Presentation of educational awards
 Certificates of appreciation to continuing medical education examiners
4. Presentation of AMA-ERF check to Illinois medical schools
5. Introduction of special guests
6. President's Address
 Robert C. Hamilton, M.D.
7. Reports of reference committees
 Amendments to Constitution and Bylaws
 Committee A-officers, administration, finances, budgets, medical-legal and governmental affairs
 Committee B-government health programs, including health care finance and economics
 Committee C-education, manpower, clinical medicine, scientific matters and medical services
 Committee D-public relations and miscellaneous business
8. New business and announcements
9. Recess until 2:00 p.m.
10. Call to order by the speaker
11. Reports of Reference Committees
12. New business
13. Recess until 9:00 a.m., Sunday, April 28, 1985
14. ISMS/ISMSA Raffle
15. IMPAC Reception

Third Session

9:00 a.m. ——— Sunday, April 28, 1985 ——— Chicago Marriott O'Hare Hotel
Grand Ballroom

1. Call to Order by the Speaker
2. Report of Credentials Committee
3. Induction of Morgan M. Meyer, M.D., President-elect, into office of President by Robert C. Hamilton, M.D.
4. Address of President Meyer
5. Announcements and introduction of guests
6. Reports of Reference Committees
7. Elections
 Report of Nominating Committee
 a. President-Elect (Cook County)
 b. 1st Vice-President (Downstate)
 c. 2nd Vice-President (Cook County)
 d. Secretary-Treasurer
 e. Speaker of the House (Cook County)
 f. Vice-Speaker of the House (Downstate)
 g. Trustee Terms Expiring

District	*Terms Expiring*
Third District	Richard H. Blankshain, M.D.
Fourth District	George H. Burke, M.D.
Fifth District	Robert L. Prentice, M.D.
Seventh District	Boyd E. McCracken, M.D.
Eighth District	Arthur R. Traugott, M.D.

 h. Delegates to AMA to take office January 1, 1986 and serve until December 31, 1987

 Terms Expiring

 Howard C. Burkhead, M.D., Evanston
 Alfred J. Clementi, M.D., Arlington Heights
 Robert C. Hamilton, M.D., Chicago
 Robert P. Johnson, M.D., Springfield
 Morgan M. Meyer, M.D., Lombard
 Joseph H. Skom, M.D., Chicago
 Arthur R. Traugott, M.D., Urbana
 Cyril C. Wiggishoff, M.D., Chicago

 i. Elections:
 One delegate from Cook to take office immediately and serve until December 31, 1986, as the 18th Delegate to the AMA.
 One delegate from Downstate to take office immediately and serve until December 31, 1985, as the 19th Delegate to the AMA.

 j. Alternate delegates to AMA to take office January 1, 1986 and serve until December 31, 1987

 Terms Expiring

 Randall T. Bellows, M.D., Chicago
 Jere Freidheim, M.D., Chicago
 Allan L. Goslin, M.D., Streator
 Harold Jensen, M.D., Flossmoor
 A. Beaumont Johnson, M.D., Elgin
 Carlos B. Lara, M.D., Pittsfield
 Pedro A. Poma, M.D., Melrose Park
 Warren D. Tuttle, M.D., Harrisburg
 Ronald G. Welch, M.D., Belleville

 k. Elections:
 One alternate delegate from Downstate to take office immediately and serve until December 31, 1985, as the 18th Alternate Delegate to the AMA
 One alternate delegate from Cook to take office immediately and serve until December 31, 1986, as the 19th Alternate Delegate to the AMA

 l. Judicial Panel member to take office April 28, 1985 and serve until April, 1990; nominated by ISMS President

 m. Rules and Order of Business Committee to take office April, 1985 and serve until April, 1986
 Five (5) delegates nominated by the Speaker and Vice-Speaker of the House

8. Fixing of per capita dues for 1986
9. Selection of meeting place and time for next meeting
10. Unfinished business
11. New business
12. Adjournment, *Sine Die*

ISMS Delegation to the AMA

Delegation Chairman: Morgan M. Meyer; Secretary: Robert C. Hamilton

Delegates

To serve from Jan. 1, 1984 to Dec. 31, 1985

(Elected April 24, 1983)

Howard C. Burkhead, Evanston
Alfred J. Clementi, Arlington Heights
Robert C. Hamilton, Chicago
Robert P. Johnson, Springfield
Morgan M. Meyer, Lombard
Joseph H. Skom, Chicago
Arthur Traugott, Urbana
Fred Z. White, Chillicothe
Cyril C. Wiggishoff, Chicago

To Serve from Jan. 1, 1985 to Dec. 31, 1986

(Elected April 8, 1984)

Audley F. Connor, Jr., Chicago
David S. Fox, Chicago
Lawrence L. Hirsch, Northbrook
Henrietta Herbolsheimer, Chicago
Michael L. Nieder, Chicago
Joseph R. O'Donnell, Glen Ellyn
P. John Seward, Loves Park
Fred Z. White, Chillicothe
George T. Wilkins, Jr., Edwardsville

Honorary Members

Frank J. Jirka, Jr., Barrington Hills
Burtis E. Montgomery, New York
John J. Ring, Mundelein

Alternates

To serve from Jan. 1, 1984 to Dec. 31, 1985

(Elected April 24, 1983)

Randall T. Bellows, Chicago
Jere Freidheim, Chicago
Allan Goslin, Streator
Harold Jensen, Flossmoor
A. Beaumont Johnson, Elgin
Carlos B. Lara, Pittsfield
Pedro A. Poma, Melrose Park
Warren D. Tuttle, Harrisburg
Ronald Welch, Belleville

To Serve from Jan. 1, 1985 to Dec. 31, 1986

(Elected April 8, 1984)

James H. Andersen, Oak Brook
James DeBord, Peoria
Alfred J. Kiessel, Decatur
Joseph Perez, Rockford
Clifton L. Reeder, Wilmette
Harry A. Springer, Evanston
Robert Vanecko, Chicago
Nancy Zamora, Rockford

Notification of Annual IMPAC Meeting

The 1985 Annual Meeting of the Illinois State Medical Society Political Action Committee (IMPAC) will be held on Friday, April 26, 1985, *immediately following the adjournment of the ISMS House of Delegates.*

11:15 a.m. (approx.)
Grand Ballroom
Chicago Marriott O'Hare Hotel
Chicago, Illinois

All members of IMPAC are invited and encouraged to attend.

The 1985 IMPAC Nominating Committee has met and nominated the following individuals for membership on the IMPAC Council:

Jere E. Freidheim, M.D., Chicago
Robert C. Hamilton, M.D., Chicago
Harold L. Jensen, M.D., Flossmoor
James M. Laidlaw, M.D., Champaign
Tassos P. Nassos, M.D., Northbrook
Edward F. Ragsdale, M.D., Alton
Clifton L. Reeder, M.D., Wilmette
Earl E. Suckow, M.D., Mt. Prospect
Warren D. Tuttle, M.D., Harrisburg
Cyril C. Wiggishoff, M.D., Chicago

Committees of the House of Delegates

Committee on Rules and Order of Business

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the session of the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

Resolutions submitted after the deadline for receiving resolutions (30 days prior to the annual or interim meeting) must be approved by the Committee on Rules and Order of Business, or by a two-thirds vote of the House, before they will be considered as business of the House of Delegates.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

Committee on Credentials

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform other such duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

Tellers and Sargeants At Arms

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.

Reference Committee on Amendments to Constitution and Bylaws

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws, matters relating to policy, and peer review concerns.

Reference Committee A

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to officers, administration, finances, budgets, medical-legal matters, and governmental affairs.

Reference Committee B

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to government health programs, including cost containment, health care financing and economics.

Reference Committee C

This committee shall consider and submit it recommendations to the House of Delegates upon reports and resolutions relating to education, manpower, clinical medicine, scientific matters and medical services.

Reference Committee D

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to public relations and miscellaneous subjects.

Resolutions
1985 Annual Meeting
ISMS House of Delegates

The following resolutions were received at ISMS headquarters by February 20 and, according to provisions of the bylaws, are printed in IMJ by title and subject. Final deadline for resolutions was March 22. At this writing it is anticipated that other resolutions will have been submitted for consideration before that deadline. These will be included in the Delegates' packet of materials.

Number	Subject	Submitted by
Memorial	Stanley Budrys, M.D.	Jere E. Freidheim, M.D., Chairman, Cook County Delegation
Memorial	Warren W. Young, M.D.	Jere E. Freidheim, M.D., Chairman, Cook County Delegation
Memorial	Louis B. Tarsinos, M.D.	Allan L. Goslin, M.D., Trustee
1 (A-85)	Advertising	Sam J. Sugar, M.D.
2 (A-85)	Usual, Customary or Reasonable Reimbursement	Alfred J. Clementi, M.D., for the Board of Trustees
3 (A-85)	Policy Statement on "Blood Availability"	Alfred J. Clementi, M.D., for the Board of Trustees
4 (A-85)	ISMS Policy Statement on "Reconstructive Surgery"	Alfred J. Clementi, M.D., for the Board of Trustees
5 (A-85)	ISMS Policy Statement on "Smoking"	Alfred J. Clementi, M.D., for the Board of Trustees
6 (A-85)	ISMS Policy Statement on "Advertising"	Alfred J. Clementi, M.D., for the Board of Trustees
7 (A-85)	County Societies	Alfred J. Clementi, M.D., for the Board of Trustees
8 (A-85)	Capitated Health System Insolvency Insurance	Jere E. Freidheim, M.D., Chairman, Cook County Delegation
9 (A-85)	Malpractice Premiums	Samuel J. Schimel, M.D.
10 (A-85)	Membership Dues Stabilization	Harlan Failor, M.D., Lewis Trupin, M.D., and Robert Welke, M.D. for the Champaign County Medical Society
11 (A-85)	PPO Terminology	William P. Gibbons, M.D., for the DuPage County Medical Society
12 (A-85)	Inappropriate Use of Procedures to Improve Athletic Performance	Raymond A. Dieter, M.D., for the DuPage County Medical Society
13 (A-85)	Legal Defense Insurance	Edward K. DuVivier, M.D. for the Madison County Medical Society

14 (A-85)	Attorneys' Fees	Edward K. DuVivier, M.D., for the Madison County Medical Society
15 (A-85)	Medical Staff Privileges	Garth D. Smith, M.D., for the DuPage County Medical Society
16 (A-85)	Free-Standing Ambulatory Care Clinical Laboratories	Erlo Roth, M.D., for the DuPage County Medical Society
17 (A-85)	Malpractice Reform by Constitutional Amendment	Lorris M. Bowers, M.D., for the Peoria Medical Society
18 (A-85)	AMA Membership	Lorris M. Bowers, M.D., for the Peoria Medical Society
19 (A-85)	Terms of Office of Delegates to the AMA	Paul M. Norris, M.D., for the Peoria Medical Society
20 (A-85)	Geographic Location of ISMS Meetings	James R. DeBord, M.D., for the Peoria Medical Society
21 (A-85)	The Roles of a Medical Staff and Governing Board in Credentialling	Donal D. O'Sullivan, M.D.

YOU'RE INVITED

To a complimentary Public Affairs Breakfast on Saturday, April 27, 1985, 7:30 a.m., Chicago Marriott O'Hare Hotel 8535 W. Higgins Rd. Chicago, Illinois 60631

Tickets for the breakfast will be available at convention registration during the ISMS Annual Meeting on a first come, first served basis.

For further information, please contact James Tierney at ISMS offices, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602. Telephone (312) 782-1654 or (800) 782-ISMS.

You're Invited

To the IMPAC Silver Anniversary Celebration
25 years of physician involvement in medical politics

April 27, 1985 6:30 p.m.

O'Hare Marriott (Room to be announced)

*Suggested Dress— IMPAC Silver Anniversary Pin**

Come One, Come All!

**IMPAC memberships will be available at the door.*

Program Summary By Days

WEDNESDAY, APRIL 24, 1985

2:00 p.m.	ISMIE Executive Committee Meeting
4:00 p.m.	Annual ISMIE Membership Meeting
5:00 p.m.	ISMIE Board of Governors Meeting

THURSDAY, APRIL 25, 1985

9:00 a.m.	ISMS Board of Trustees Meeting

FRIDAY, APRIL 26, 1985

7:30 a.m.	ISMS Board of Trustees Meeting
7:30 a.m.	Rules and Order of Business Meeting
8:00 a.m.	Registration
8:00 a.m.	CMS Caucus
8:30 a.m.	Meeting of Reference Committee Members
8:30 a.m.	Credentials Committee
9:30 a.m.	House of Delegates
11:15 a.m.	IMPAC Annual Meeting
11:30 a.m.	District Meetings
11:30 a.m.	Delegates' Buffet
1:30 p.m.	
1:30 p.m.	Reference Committees
4:30 p.m.	AMA Delegation Meeting
7:00 p.m.	President's Night

SATURDAY, APRIL 27, 1985

7:30 a.m.	Public Affairs Breakfast
8:00 a.m.	Registration
8:30 a.m.	CMS Caucus
9:00 a.m.	Credentials Committee
9:30 a.m.	House of Delegates
10:00 a.m.	Medical Student Section Meeting
11:00 a.m.	Resident Physicians Section Meeting
11:30 a.m.	Fifty Year Club Luncheon
1:00 p.m.	CMS Caucus (if necessary)
1:30 p.m.	Credentials Committee
2:00 p.m.	House of Delegates
4:45 p.m.	District 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12 Caucus
6:30 p.m.	IMPAC Reception

SUNDAY, APRIL 28, 1985

7:30 a.m.	ISMS Board of Trustees Meeting
8:00 a.m.	Registration
8:30 a.m.	Credentials Committee
9:00 a.m.	House of Delegates
	Board of Trustees Reorganization Meeting Immediately Following House Adjournment.

Illinois State Medical Society

Illinois State Medical Society Auxiliary

Ticket to Adventure

Second Annual Benefit Raffle

for the

Educational and Scientific Foundation's

Medical Student Loan Fund

Grand Prize: Trip for two to Maui, Hawaii

Including one week's lodging at a private condo and rental car
(subject to availability; other restrictions may apply)

2nd PRIZE: Week at Sea Lord Motor Hotel, Palm Beach, Florida (air fare for two included)

3rd PRIZE: Drake Hotel weekend, Chicago

4th PRIZE: Set of travel luggage

5th PRIZE: 4th of July weekend in Lake of the Ozark's condo

6th PRIZE: Weekend stay at the Chicago Marriott Hotel

7th PRIZE: Miracle Morning at the Chicago Elizabeth Arden Salon

Other prizes to be announced

Drawing Held April 27, 1985
At ISMS Annual Meeting

Ticket books have been mailed to all
ISMS/ISMSA members

$6.00 per ticket

$50.00 per 10-ticket book
Winners need not be present

Contributions to the ISMS Educational and Scientific Foundation are normally tax deductible to the extent allowed by law.

ISMS Auxiliary
57th Annual Meeting
O'Hare Marriott Hotel

WEDNESDAY, APRIL 24

Noon	Pin and Gavel Luncheon (Past Presidents Only)
Afternoon	Leisure Time
2:00 p.m.	Pre-Convention Board of Directors Meeting
7:00 p.m.	Board of Directors Dinner
Evening	Auxiliary Hospitality Suite

THURSDAY, APRIL 25

8:00 a.m.	House of Delegates Registration
9:00 a.m.	First House of Delegates Session Call to Order and Greetings Opening Ceremonies Reading of Rules Appointment of Reading and Reference Committees Reading of Resolutions Reading of Budget President's Report to House of Delegates
	Keynote Speaker: James Sammons, M.D., Executive Vice President of the American Medical Association
11:00 a.m.	Reference Committee Hearings Health Concerns Organizational Affairs
Noon	Reception for ISMSA Past Presidents
12:15 p.m.	President's Luncheon (Guests & Delegates Welcome)
1:15 p.m.	Awards Presentations
2:00 p.m.	Nominating Committee Report
	Nominations and Election Instructions
	County Presidents' Reports
3:30 p.m.	Guest Speaker: Eugene Kennedy, Ph.D., novelist, biographer and psychologist
Evening	Evening of dinner and theatre, Drury Lane Theatre, Oakbrook

FRIDAY, APRIL 26

7:00 a.m.	Caucus Meetings
7:45 a.m.	County Presidents-Elect Meeting
9:00 a.m.	Second House of Delegates Session Election Results Guest Speaker: Mary Kay McPhee, AMAA President-Elect Reference Committee Reports Budget Approval
10:45 a.m.	Workshops: Legislation Health Projects

Noon	Installation Luncheon Annual Meeting Adjournment
2:15 p.m.	Board of Directors Photograph
2:30 p.m.	Post-Convention Board of Directors Meeting
Afternoon	Leisure Time
7:00 p.m.	ISMS President's Night—honoring Robert C. Hamilton, M.D.

SATURDAY, APRIL 27

7:30 a.m.	ISMS Public Affairs Breakfast
Late Afternoon	ISMS/ISMSA Benefit Raffle for Medical Student Loan Fund

Schedule of Associated Meetings

Wednesday, April 24, 1985
4:00 p.m.

Illinois State Medical Inter-Insurance Exchange Annual Meeting of Members

The principle purpose of this meeting will be the election of members to the Exchange Board of Governors for the 1985-86 term. All members of the Exchange are urged to participate either by personal attendance or by timely execution of their proxy statement.

Friday, April 26, 1985
11:15 a.m.

Illinois State Medical Society Political Action Committee (IMPAC) Annual Meeting

Friday, April 26, 1985
7:00 p.m.

President's Night

Saturday, April 27, 1985
7:30 a.m.

ISMS Public Affairs Breakfast

Tickets available at ISMS registration desk

Saturday, April 27, 1985
10:00 a.m.

Medical Student Section Spring Seminar

Annual business meeting and election of officers

Saturday, April 27, 1985
Noon

Resident Physicians Section

Annual business meeting and election of officers

Saturday, April 27, 1985
6:30 p.m.

IMPAC Silver Anniversary

Reception

CONVENTION '85

The 145th Annual Meeting
of the
Illinois State Medical Society
will be held at the
Chicago Marriott
O'Hare Hotel
8535 W. Higgins
(Cumberland & Higgins)
Chicago, Illinois
April 26-28, 1985

- ISMS House of Delegates
- President's Night
- Annual IMPAC Meeting
- Public Affairs Breakfast
- IMPAC Reception

Further information about convention may be obtained by contacting the Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago Illinois, 60602; (1-312-782-1654).

Plan Now to Attend Convention '85

THE CHICAGO MARRIOTT O'HARE HOTEL
8535 W. Higgins
Chicago, Illinois 60631
(312) 693-4444

ISMS—ISMSA
1985 Annual Meeting
April 24-28, 1985

Please reserve _____ room(s) for _____ persons

Name (Print) _____

Address _____

City _____ State _____ Zip _____

Will arrive on _____
(day) (date) (time)

Will depart on _____
(day) (date) (time)

☐ This Reservation is Guaranteed Payment for Late Arrival By:

Firm _____

Address _____

City _____ State _____ Zip _____

Note: Please Be Sure Your Reservation Reaches The Hotel 21 Days in Advance To Insure Your Accommodations. Otherwise Accommodations Will Be On A Space Available Basis Only.

Featuring 706 Luxurious Guest Rooms—indoor/outdoor year round pool—complete health club—saunas—hydrotherapy pools—outdoor tennis courts—Kona Kai Restaurant, exotic dining in Polynesian atmosphere—Gambits, dining and dancing in a plush elegant setting—plus two other restaurants and lounges—conveniently located off the Kennedy Expressway—featuring complimentary airport limousine service to O'Hare International—The FINEST hotel in the O'Hare area.

No. of Rooms	Type of Room	Rate
_____ SINGLE ROOMS	(1 Person)	$74.00
_____ DOUBLE ROOM	(2 Persons)	$84.00
_____ TRIPLES (3 Persons)		
_____ QUADS (4 Persons)		

Rooms subject to 10.1% Illinois and City room tax.

Sharing with _____
Please submit only one card when sharing accommodations.

Reservations held only until 6:00 P.M. local time, unless guaranteed by one night's advance deposit or Company guarantee of payment. Check-out time is 1:00 P.M., check-in after 3:00 P.M.

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MRI reveals physical and chemical differences between normal **and diseased tissue**

*These views are obtained using no contrast agents, and without interference of bony artifacts... allowing a new— very clear—3 dimensional display of topical anatomy in investigations in these fields:**

- Central nervous system disorders: multiple sclerosis, syringomyelia, spinal cord tumors, Arnold Chiari malformations, infarcts, acoustic neuromas, pituitary tumors, brain tumors
- Chest, abdomen, liver, kidney, pelvis
- Muscular-skeletal system
- Hilar and mediastinal masses
- Breast malignancies
- Kidney transplant rejection
- Evaluation of blood flow
- Multi-gated cardiac studies

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BRENT M. GREENBERG, M.D.
Diplomate American Board of Radiology

MARK GREENBERG, M.D.
Diplomate American Board of Radiology

*Additional diagnostic information on page 206

Viewbox

(Continued from page 191)

Diagnosis: Cytomegalovirus Infection



Figure 3—This radiograph was taken four days after Figure 2. There has been marked progression of extensive lung nodules. The patient died seven days later.

Cytomegalovirus (CMV) Infection in the lung typically presents as diffuse nodular or reticulonodular lung densities. Bone marrow transplant (BMT) is complicated by CMV infection in 10-50% of patients.

Leukemic Lung Involvement—This patient was treated with chemotherapy and total body irradiation prior to BMT. Leukemic lung involvement would represent recurrence and would not occur this soon. In addition, leukemias primarily involve the hilar and mediastinal nodes. When tumor cells do extend into the peribronchial and perivascular tissues, there is usually readily recognizable enlargement of hilar nodes.

Acute Pulmonary Hemorrhage—This is manifest as widespread, patchy alveolar densities that clear gradually over a period of days, not as diffuse intestinal lung changes as seen in this patient.

Graft Versus Host Disease—Both acute and chronic forms affect primarily skin, liver, and the gastrointestinal system. Pulmonary involvement can occur as a late sequela, several months after bone marrow transplantation, in the form of chronic obstructive bronchiolitis. This patient's lung abnormalities developed too soon after transplant to be considered late pulmonary manifestations of graft versus host disease.

Cytomegalovirus (CMV) is a double-stranded DNA virus and a member of herpesviruses (HSV) sharing many properties with varicella zoster (VCZ) and herpes simplex viruses. It is morphologically indistinguishable from the other herpesviruses. It produces large intranuclear (9 to 15nm) and smaller cytoplasmic (2 to 4nm) inclusions in infected cells.[1] Key features of the virus are its worldwide distribution, multimodal transmission, tissue pleiotropism and oncogenic potential. Hallmarks of the biology of CMV are silent primary infection, persistence, latency, and reactivation of the virus; hallmarks of all the herpesviruses. The immunologic determinants of CMV diseases and the immunologic consequences of infection with the virus are probably greater than for the other herpesviruses. HSV and VCZ reactivation occur most usually without obvious immunodeficiency, but CMV seems to require considerable disturbance of immunoregulation for symptomatic reactivation. Furthermore, the effects of CMV on T-cell subset interplay seem to be greater than those produced by any other known human virus. Only infection with the virus of Acquired Immunodeficiency Syndrome (AIDS) produces larger and more lasting reversals of helper-to-suppressor T-lymphocyte ratios.[2]

Cytomegalovirus has a worldwide distribution. A recent World Health Organization survey of healthy blood donors from 26 countries of widely varying geographic and economic climates found evidence of antibodies to CMV in 40-50% of persons from industrialized countries and in nearly 100% of persons in developing nations.[3] In the majority of populations studied, the age at which CMV antibody is acquired is dependent on race, socioeconomic conditions and sex.[4]

In common with other herpesviruses, CMV can persist for prolonged periods of time in the infected host. In both children and adults, viral excretion may occur for months to years. Virus can be cultured from urine, saliva, buffy coat, breast milk, cervix, semen, and feces. The potential sources of transmission are multiple. Direct transfer of infected saliva as well as venereal spread are likely modes of transmission.[3] The diagnosis of CMV infection relies on demonstration of the virus or evidence of an immune response to CMV and cannot be made on purely clinical grounds. It can be made, however, by the demonstration of a rising antibody titer. A fourfold rise is considered significant. The complement-fixation antibody test is more widely available and although it is known to be relatively insensitive for the detection of low levels of antibody, this test suffices in most instances. The most sensitive diagnostic is immunofluorescence for the detection of virus-specific IgM antibody.[1]

Neonatal Infections—Congenital

CMV is the most frequent cause of intrauterine infection in the United States, with involvement of 1 to 2% of all newborn infants in the country.[3] The symptom complex of classic CMV inclusion disease is well recognized, and the diagnosis should be considered in any infant presenting at birth with microcephaly, hepatosplenomegaly, jaundice, petechiae, thrombocytopenia, chorioretinitis, or intracranial calcifications (Figures 4, 5).[5] Infants with generalized viral infection usually present with hepatosplenomegaly and persistent jaundice earlier than those with metabolic or ductal cholestatic jaundice. Approximately 15% of infants with CMV infection develop evidence of chronic liver disease which may result in cirrhosis.[6] Whitley, *et. al.*,[7] report two infants who developed a protracted pneumonitis with lower respiratory obstruction beginning at one month of age. CMV was found to be a major causative factor. No gross immunologic defects as predisposing causes were detected. This report indicates the pathogenic potential of CMV, when acquired early in life, even in the absence of immunosuppression.

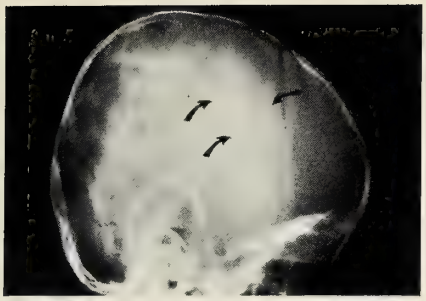


Figure 4—Lateral plain radiograph of the skull in a child with congenital cytomegalovirus infection. Note multiple scattered intracranial calcifications (arrows).

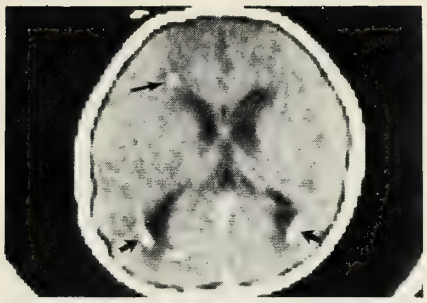


Figure 5—Computed tomography of the head in a child with cytomegalovirus infection. Note intracranial calcifications (arrows) which are in a typical periventricular location.

Viral excretion, antibody response, and specific cell-mediated immunity were studied in 104 children with congenital CMV infection followed from birth. The study population demonstrated prolonged viral shedding and stable, moderate levels of serum antibody. The majority of patients ceased salivary shedding of CMV by two years of age but continued to have viruria through the fifth year. Patients who had symptomatic infection or CNS sequelae were similar to asymptomatic patients with regard to both viral excretion and antibody response. Although symptomatic patients had significantly weaker specific blastogenic responses from one to seven years of age, the majority of patients from both groups had no detectable response to CMV through their fifth year. The presence of a positive response was associated with cessation of viruria.[8]

The spectrum of disease from intrauterine CMV infection varies from severe cytomegalic inclusion disease to inapparent infection. Since only a small percentage of congenital CMV infections present with clinical symptoms at birth, the majority of cases are undiagnosed. Contributing to the problem of diagnosis is the fact that CMV infection in pregnancy is also rarely symptomatic. The prevalence of active infection has been found to be about 10% of pregnancies.[3]

Neonatal Infections—Acquired

Acquired CMV infection is usually contracted by three months of age and is thought to be the result of perinatal transmission of infective virus during passage through the birth canal, in a manner analogous to perinatally transmitted herpes-simplex infection.

While the majority of infants have subclinical infections, there may be a respiratory illness, hepatosplenomegaly, lymphadenitis, and a rash.[3] These effects are usually mild and transient, but occasionally an infant may have severe respiratory infection. Followup of infants with acquired CMV infection showed that their IQ and motor function are comparable to those of matched controls.[9]

Infections in Healthy Children and Adults

The majority of CMV infections in healthy adults are also subclinical. Symptomatic illness may occur, however, and it occurs with increased frequency in young adults. The best defined illness caused by CMV in healthy adults is a mononucleosis syndrome. This syndrome is characterized by fever and malaise, usually absence of significant pharyngitis or cervical lymphadenopathy, and often mild hepatitis and splenomegaly. Despite prolonged fever, most patients do not appear acutely ill and the diagnosis can be confirmed by viral culture of saliva and/or urine and by serologic assessment of CMV antibodies in acute and convalescent sera.[3]

Patients gradually improve over 3-6 weeks with resolution of fever and disappearance of atypical lymphocytes from peripheral blood. Much less frequent manifestations of CMV "mononucleosis syndrome" include interstitial pneumonia, myocarditis, polyneuritis (Guillain-Barre syndrome), hemolytic anemia, and thrombocytopenic purpura. Rarer still have been encephalitis, jaundice, granulomatous hepatitis, and frank arthritis with effusions.[1] Rare instances of ulcerative bowel disease and chorioretinitis also have been described in patients who were not apparently immunosuppressed.[2]

Infections in Recipients of Blood Transfusions

CMV infection can also be transmitted by simple blood transfusion and there is a direct relationship between occurence of infection and number of units of blood transfused. Use of CMV antibody-positive blood greatly increases the possibility of disease transmission (Figure 6).[1,3,9] Although numerous attempts have been made to detect CMV in donor blood samples, only one has been successful. Using cytohybridization techniques, Pagano and his group have demonstrated CMV genome acid in certain units of CMV antibody-positive blood.[9] Post-transfusion infection is frequently subclinical.

Infections in Compromised Hosts

In the normal host, the defense

Figure 6—A 72 year old man who developed cytomegalovirus lung infection after multiple blood transfusions. Note extensive reticulonodular lung densities.

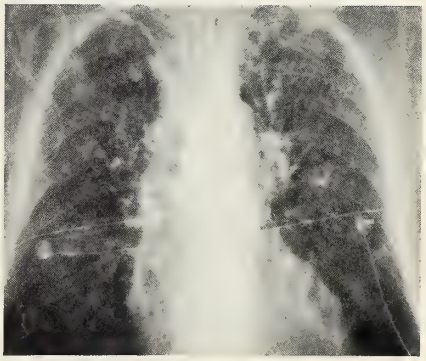


Table I

Patterns of Cytomegalovirus Infection
Neonatal
Congenital
Acquired
Healthy Children and Adults
Mononucleosis type syndrome
After blood transfusions
Compromised Hosts
After allograft transplants
Other immune supressed patients

against pathogenic microorganisms consists of several mechanisms. An abnormality of any one of these defense mechanisms is associated with a rather specific type of infection. When cell-mediated immunity is defective, infections caused by the so-called obligate and facultative intracellular microorganisms may develop. Viruses belong to this category.[10,11]

An understanding of the role of CMV in the compromised host has increased with the understanding of the epidemiology of CMV in normal individuals. Immunosuppressed groups include those with combined immune deficiencies, neoplasia, rheumatic disease when cytotoxic drugs are used, and recipients of organ transplants.[12] The pathogenic potential of the virus is enhanced in these individuals, and although subclinical infections are still frequent, the spectrum of clinical symptoms is more diverse than in healthy, nonimmunosuppressed populations. One possible explanation for the increased clinical symptomatology observed in patients with malignant disease and/or receiving immunosuppressive drugs is that viremia occurs more frequently.

The pathogenesis of CMV infection in the compromised host is complex. As in normal persons, primary infection may occur after exposure to exogenous virus in blood products or other sources. In the case of transplanted tissue, however, virus may be transmitted in the organ allograft itself, *e.g.*, kidney, heart, or bone marrow, or may be reactivated from a latent state within the patient.[1] Most frequently it occurs as asymptomatic shedding of a reactivated virus. Reactivation occurs when cellular immunity is compromised, and the greater the degree of immunodeficiency, whether owing to the underlying disease or to iatrogenic intervention, the more likely the infection is to progress to dissemination.[12]

In immunosuppressed patients, pneumonitis is the most common manifestation of the disease,[3] and in fact, the infection usually appears as an interstitial pneumonitis.[13] The viral infection may be severe and life-threatening, and may progress to a disseminated form in which virtually every organ may be involved including the lung, liver, spleen, kidneys, adrenals, pancreas, gastrointestinal tract and central nervous system.[1]

The group of compromised hosts in which CMV has gained most attention is that of the recipients of transplanted organs. Infection has been recognized in recipients of cardiac, hepatic, bone marrow, and renal allografts. After allogenic transplantation, the most important and devastating manifestation of CMV infection is CMV pneumonia.[12] The patient presented here was a bone marrow transplant recipient.

CMV Pneumonia-Bone Marrow Transplant

Allogenic bone marrow transplantation (BMT) is being increasingly utilized in the treatment of aplastic anemia, immunodeficiency syndromes, and malignant diseases. Despite the overall success of this approach, a number of serious and potentially fatal complications may occur following transplantation.[14] Infection remains one of the main problems; the other is graft-versus-host disease (GVHD).[15]

Prior to BMT, patients generally require conditioning therapy. Typically, this involves high doses of chemotherapy and whole body or total lymphoid irradiation. This conditioning therapy must suppress the recipient's immunity sufficiently to allow sustained engraftment and prevent rejection of the transplant. When the transplant is used for the treatment of malignancy, this therapy must also completely eradicate neoplastic cells.

The transplant procedure involves intravenous infusion of 1 to 5×10^8 bone marrow cells per kilogram of recipient body weight. These cells are collected from the donor by multiple bone marrow aspirations. The donor bone marrow cells engraft and establish normal hematopoiesis in the recipient, usually within three to four weeks.[14]

Representatives of 17 bone marrow transplant teams met to discuss the problem of infection after BMT.[15] With experience of more than 2200 transplanted patients over the past ten years, they found that deaths due to bacterial infection have greatly diminished and that the major early problem today is fungal and CMV infection. Between 10 and 50% of patients develop CMV infection after BMT, and approximately 60% of cases of CMV pneumonia prove fatal. Risk is highest between five and thirteen weeks after transplant, with the peak at eight weeks. Factors which increase the incidence of CMV infection and CMV pneumonitis include being a Caucasian, GVHD, age <12 years, lung radiation greater than 6 Gy, preceding recipient CMV seropositivity, recipient seronegativity with donor seropositivity, granulocyte transfusions, and degrees of recipient/donor HLA matching which are less than fully compatible.[10,14-16] Although some authors ascribe the pneumonitis to CMV, others consider it to be multifactorial in origin (associated with previous irradiation, cytotoxic therapy, and GVHD).[10]

Most BMT patients with CMV pneumonia develop a dry cough, dyspnea, hypoxia and fever. The characteristic radiographic findings are diffuse reticulonodular or interstitial infiltrates. While the term "interstitial pneumonia" has been applied, the lung involvement is actually a mixed interstitial and alveolar process (Figure 3). Since the radiographic appearance of CMV pneumonia is both varied and entirely nonspecific, open lung biopsy must be performed to provide the specific diagnosis and to rule out other causes of diffuse pulmonary infiltrates.

An increased pulmonary uptake

of gallium citrate (Ga67) has been demonstrated following renal transplantation in two patients, each of whom had a fourfold rise in CMV complement-fixing antibody titer. In both patients the images were positive prior to the knowledge of the rise in antibody titer and prior to other clinical or radiologic signs of pulmonary involvement.[18]

Pathologic Manifestations

The microscopic diagnosis of interstitial pneumonia was based on edematous or fibrotic thickening of alveolar septums together with an interstitial inflammatory infiltrate composed of lymphocytes, plasma cells, histiocytes, or any combination thereof.[17] Lung involvement may be diffuse or localized and may include macro- or micronodules (miliary disease) which show focal necrosis. Pulmonary changes may be modified by concomitant infection with a variety of other agents.

Therapy and Prophylaxis

Although there have been very definite advances in the use of antiviral therapy against other herpes viruses, developments of treatment modalities for CMV infections have not yet yielded effective results. The nature of the replicative cycle of CMV, as well as our inability to define processes specific for inhibition of viral replication, pose problems of significant magnitude at the present time.[5]

Therapeutic trials using interferon, nucleoside analogs, or a combination of these two preparations have not provided satisfaction, although interferon has shown an antiviral effect in renal transplant patients. Acyclovir has prevented recurrent HSV infection after BMT,[19] but has a selective toxicity for the herpes simplex virus. CMV only exhibits limited susceptibility at high concentrations of the drug. So far, combinations of acyclovir with interferon or another drug have not been successful. Newer drugs (such as foscarnet or phosphonoformic acid), which are active against CMV in vitro, have only been given occasionally, and the results are hard to interpret.[10]

Passive immunization has been shown to prevent CMV disease in certain BMT recipients,[19] and investigators have been interested in exploring the potential capacity of live CMV vaccines to prevent transplacental transmission of human CMV without apparent vaccine reactivation during pregnancy.[20] There are concerns relative to the prophylactic use of a live CMV vaccine. Among these are the problem of the lack of markers of attenuated forms of CMV, the fact that an attenuated virus might persist in a viable form in the host for life, and the possibility of reactivation of a latent attenuated virus. In addition, vaccine contains only one CMV strain, whereas there are a number of wild strains. Finally, CMV may have oncogenic potential (it is related to Epstein-Barr virus and HSV, both of which have known oncogenic capabilities).[3,9] Currently, two live CMV vaccines are available, and studies have shown that vaccine stimulates humoral and cell-mediated immunity and thus far has not shown reactivation.[9] ◀

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SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies

From the Department of Registration and Education (DRE)

Disciplinary Orders

- *Kamaluddin Lakhani, M.D. (lic. #36-53855)* Effective January 8, 1985, the medical license of Dr. Lakhani was suspended for an indefinite period.
- *Jose Lillo, M.D. (lic. #036-052133)* On January 14, 1985, the medical license of Dr. Lillo was suspended indefinitely.
- *Jerome G. Peters, M.D. (lic. #36-47713)* Effective January 13, 1985, the medical license of Dr. Peters was suspended for an indefinite period.

(Source: Orders from the Director of DRE)

Summary Report of Activities of the Medical Disciplinary Board (MDB)

In January, the MDB released a report of its 1984 activities. The figures showed that there were 352 total complaints made against physicians and chiropractors in 1984. During the year there were 6 licenses revoked, 26 suspended, 13 placed on probation and 4 physicians reprimanded.

The MDB also reported that in 1984 it received 585 mandatory reports. The sources of these reports are as follows: health facilities—27 reports filed; professional societies—1 report filed; insurance companies—518 reports filed and state agencies—32 reports filed. Thus far, there have been only two disciplines (suspensions) taken in response to information supplied in a mandatory report. This experience is similar to that of other states having mandatory reporting laws.

(Source: December 1984 Quarterly Report of the Medical Disciplinary Board)

From the Department of Public Health (IDPH)

Vaccine Shortage

IDPH reports that there is a shortage of DPT vaccine in public health clinics and for providers of Medichek recipients. While it is not considered acute, physicians have been asked to hold off on providing DPT vaccine at the 18 month and the fourth or fifth year doses. Infants are to receive the highest priority for the vaccine.

The IDPH would be interested in hearing from non-public health and non-Medichek physicians who are having similar problems getting vaccine for their patients.

Physicians are advised not to substitute other immunizations for the DPT, such as the DT vaccine, which does not contain the pertussis vaccine. Children who receive this type of vaccine will not be protected from pertussis, since there is no pertussis—only vaccine available. Providing later doses of DPT to those receiving the DT vaccine could cause problems. In addition, giving fractional doses of DPT vaccine in order to stretch out its availability is not considered valuable.

IDPH anticipates there will be additional supplies of DPT vaccine by the end of the year, through either additional sources or increased production by the vaccine manufacturer.

For additional information, contact the IDPH Division of Communicable Diseases, 525 West Jefferson, Springfield, IL or call 217-782-3300.

(Source: Phone conversation with Director of Division of Communicable Diseases)

Hospital Licensing Board Actions

The IDPH Hospital Licensing Board has approved draft rules, soon to be published for public comment in the *Illinois Register,* which would permit a hospital to grant to staff physicians additional privileges to utilize their office employees for patient services within a hospital.

A second draft rule to be published for public comment would expand the types of personnel permitted access to operating rooms. In general, the draft rule would permit hospitals to allow employees, as well as others granted permission by the attending physician, operating surgeon and chief of surgery, access to the operating room.

The Board is still discussing the need to modify the current rules governing due process for medical staff members and the role of non-employed allied health personnel in hospitals.

(Source: January 23, 1985 meeting of the Hospital Licensing Board)

From the Department of Alcoholism and Substance Abuse (DASA)

Triplicate Prescription Theft Alert

A new triplicate blank theft scam is in operation in Chicago and the surrounding counties. Phone calls by persons misrepresenting themselves as employees for DASA and the Department of Registration and Education (DRE) are being made to oncology clinics, medical clinics and other professional office complexes. These persons are attempting to get information on recent shipments of triplicate blanks.

Once this information has been obtained, these persons will call back posing as state employees to say that the computer malfunctioned and that erroneous serial numbers were issued to a physician. At this point the caller will attempt to have the prescription pads picked up by a messenger service.

DASA urges physicians to alert their receptionists and other office personnel to the workings of this confidence scheme.

Triplicate prescription blanks are returned to the State only under the following circumstances:

1. Pursuant to a state disciplinary action against a physician, DRE investigators are authorized to seize triplicate blanks, provided they display official credentials and issue an official receipt for the blanks seized. They should also have a copy of the disciplinary order.
2. Officers or investigators of federal, state or local law enforcement agencies may be conducting an investigation and may be directed to seize triplicate blanks. Again, these people must show official credentials and issue an official receipt for any blanks seized.
3. Following a telephone or written notification by DASA's Triplicate Prescription Control Section, a physician could be instructed to return destroyed, damaged, expired, or otherwise unusable triplicate blanks to DASA via a carrier *chosen by the physician.*
4. Following written notification from DASA, a physician or his family or estate may be instructed to return unused triplicate blanks in the event the physician retires, relocates out of Illinois, or dies. Again, the physician or his family will be asked to choose the method of returning the blanks.

IMPORTANT: If you have been contacted to return triplicate blanks in any other manner than described above, immediately notify the triplicate prescription control section at one of the following numbers:
In Chicago: Ask for Mark Bishop 312/793-9500
In Springfield: Ask for Margaret Marcum 217/782-0685

(Source: Correspondence from DASA)

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Theory and Practice

Intellectual Enrichment

Illinois Society, American Association of Medical Assistants, invites all health professionals to join us April 25-28, when Chicago Chapter will host the 29th annual meeting at the Marriott Oakbrook Hotel.

The 29th annual meeting of the Illinois Society will commence with a "Welcome" for those arriving at the hotel on Thursday evening, April 25. The business session will open on Friday morning, and all members are expected to attend and participate in determining the future of our organization.

The educational portion begins Saturday morning at 8:00a.m. when George O'Hare, sales promotional manager for Sears Roebuck, will speak. Mr. O'Hare began his retailing career in sales at Sears in 1949 and has traveled to many parts of this country as well as to other parts of the world on a voluntary basis to discuss his formula for success. He has been described as one of America's best motivational speakers, and promises to offer us an opportunity for "Greater Productivity Through Increased Personal Awareness."

No educational program would be complete without a clinical segment and Robert Liszka will speak on "Understanding Holter Monitoring." Mr. Liszka, after several years with Midwest Surgical and Hospital Supply, became co-owner of Medical Systems, Inc.

Joyce P. Drake, regional director, Medic Alert Foundation, Inc., promises to tell us how "You Can Make A Critical Difference" by helping other parts of the health care and emergency services in supplying individual medical information on a confidential basis.

R.A. Alexander, M.D. of Southern Illinois Clinic, Ltd., former advisor to the Mount Vernon chapter, will discuss "Discover Health Through Diet Change." His comments will be designed to demonstrate that 80% of coronary artery disease and cancer can be eliminated through a program of diet and exercise which facilitates a better, more productive and longer life.

Phillip Thorek, M.D. will close this day with a talk on "Psychoneuro Immunology." The effects of bereavement, fear, infidelity, radical lifestyle changes and surgery are a few of the conditions that will be discussed.

All of the above speakers are well known and considered to be experts in their respective fields. It is indeed a privilege to have them with us.

Application has been made for continuing education credit through the American Association of Medical Assistants.

On Sunday morning the "Farewell Breakfast" speaker will be Ann Pearlman, selected Analyst of the Year for 1973 and 1979 by the Illinois Chapter, International Graphoanalysis Society. Her topic "Revelations of a Handwriting Analyst," promises to send us home highly motivated and with increased spirit.

For further information regarding this program please contact Chairman Synobia Payne at 312-684-6261, Co-Chairman Magda Brown, CMA, at 312-677-9016 or Illinois Society President Anna Cannon, 312-734-2645. ◀

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GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

APRIL

Allergy

Gastroesophageal Reflux
For: Allergists. Lecture, April 22, 1985, 8:00 PM, Holiday Inn Chicago City Centre. **Sponsor:** Illinois Society of Allergy & Clinical Immunology, 800 E. Northwest Highway, #101, Mount Prospect, Illinois 60056. **Fee:** $15.00 dinner. **Reg. Limit:** None. **Credit:** Category 1, 1 hour. **Contact:** Dianne K. Kubis. **Phone:** 312-255-1024.

General Medicine

Care of the Aging Patient
For: Physicians. Symposium, April 11-12, 1985, St. Louis, Missouri. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, Missouri 63110. **Fee:** $200.00. **Reg. Limit:** 150. **Credit:** AAFP prescribed, 13.5 hours; AMA Category 1, 13.5 hours; AOA, 13.5 hours. **Contact:** Loretta Giacoletto. **Phone:** (800)325-9862.

Sports Medicine

Eighth Annual Sports Medicine Symposium
For: Physicians, Nurses, Therapists. Symposium, Lectures, April 12-13, 1985, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, 465b WARF Bldg., 610 Walnut Street, Madison, Wisconsin 53705. **Fee:** TBD. **Reg. Limit:** None. **Credit:** Category 1, TBD hours; AAFP prescribed, TBD hours; AOA, TBD hours. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856. **Co-sponsor:** American College of Sports Medicine, University of Wisconsin Hospital.

Musculoskeletal Problems Associated With Sports Injuries
For: MDs. Conference, April 20, 1985, North Chicago. **Sponsor:** Department of Rehabilitation Medicine, The Chicago Medical School with the Roloke Co. **Credit:** 8 hours, Category 1. **Contact:** Eugene J. Rogers, M.D., F.A.C.P., Professor and Chairman, Department of Rehabilitation Medicine, Chicago Medical School, 3333 Green Bay Road, North Chicago, Illinois 60064. **Phone:** (312) 578-3000.

Emergency Medicine

Advances in Emergency Medicine
For: Emergency Medicine Physicians. Lecture, April 22-24, 1985, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Fee:** $335.00. **Reg. Limit** 90. **Credit:** Category 1, 24 hours. **Contact:** Robert J. Baker, M.D., Dean, (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Cardiac Rehabilitation

8th Cardiac Rehabilitation Symposium: Exercise & Heart Disease, Prevention and Rehabilitation, 1985
For: All health professionals. Symposium with workshops, April 30-May 3, 1985, Milwaukee, Wisconsin. **Fee:** $385 (physicians), $170 (others). **Reg. Limit:** None. **Credit:** Category 1, to 24 hours, Other, University of Wisconsin-Extension CEUs, to 24 hours. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg.; 610 Walnut St., Madison, Wisconsin 53705. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** 608/263-2856.

Cardiac Rehabilitation
For: M.D.s, R.N.s, P.T.s, O.T.s, Administrators, YMCA Personnel, Dietitians and Health Care Professionals. Workshop, April 15-19, June 10-14, July 15-19, November 18-22, 1985, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Philip K. Wilson, Ed. D., La Crosse Exercise Program, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse, Wisconsin, 54601. **Co-Sponsor:** La Crosse Lutheran Hospital/Gundersen Clinic, Ltd. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; Other: 3.5 CEU's from Community Health, UW-La Crosse, Extended Education/UWEX.

Infectious Diseases

Infectious Disease Update—1985
For: Physicians, Nurses. Conference, April 18-19, 1985, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut Street, Madison, Wisconsin 53705. **Co-sponsor:** University of Wisconsin School of Medicine, Department of Medicine, Section of Infectious Diseases; University of Wisconsin Hospital. **Fee:** TBD. **Credit:** Category 1, TBD hours; AAFP prescribed, TBD hours; AOA, TBD hours. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Obstetrics-Gynecology

Electronic Fetal Monitoring Workshop
For: Ob-Gyn's. Workshop, April 13, 1985, 8:30-5:00, Chicago, Illinois. **Fee:** $135 (Fellows, Jr. Fellows of ACOG) $150 (others); $68 (Life Fellows, Jr. Fellow Residents). **Credit:** Category 1, 7 hours; ACOG Program for Continuing Professional Development, 7 hours. **Sponsor:** American College of Obstetricians and Gynecologists, 600 Maryland Avenue, S.W., Suite 300 East, Washington, DC 20024. **Contact:** Robin Murray. **Phone:** 202-638-5577 Ext. 343.

12th Annual Obstetrics and Gynecology Symposium
For: Physicians. Symposium, April 25-26, 1985, St. Louis, Missouri. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, Missouri 63110. **Fee:** $200.00. **Reg. Limit:** 150. **Credit:** AAFP prescribed, 12 hours; AMA category 1, 12 hours; AOA, 12 hours. **Contact:** Loretta Giacoletto. **Phone:** (800)325-9862.

Specialty Review in Obstetrics and Gynecology
For: Obstetricians and Gynecologists. Lecture, April 29-May 4, 1985, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood St., Chicago, Illinois 60612. **Fee:** $600. **Reg. Limit:** None. **Credit:** Category 1, 48 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649 in Illinois. (800) 621-4651 outside Illinois.

Management of Complications of Gynecologic Surgery & Urology
For: Gynecologists, Urologists. Course, April 26-27, 1985, Chicago, Illinois. **Fee:** $225.00. **Credit:** AMA Category 1, 10 hours; ACOG, 10 hours. **Sponsor:** The University of Chicago, 5841 Maryland Avenue, Box 139, Chicago, Illinois 60637. **Contact:** Mary Ann Dillon. **Phone:** 312-962-1056.

Pathology

Clinical Toxicology in the Hospital and in the Medical Examiner's Office
For: Pathologists. Lecture, April 8, 1985, 7:00 PM, Drake Hotel, Chicago, Illinois. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1, 2 hours. **Sponsor:** Chicago Pathology Society, Loretto Hospital, 645 S. Central Avenue, Chicago, Illinois 60644-9987. **Co-sponsor:** Michael Reese Hospital and Medical Center. **Contact:** Marshall H. Short, MD. **Phone:** 312-626-4300 Ext. 5720.

Specialty Review in Pathology
For: Pathologists. Lecture, April 8-13, 1985, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Fee:** $600. **Reg. Limit:** 90. **Credit:** Category 1, 52 hours. **Contact:** Robert J. Baker, M.D., Dean, (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Specialty Review in Pathology: Clinical
For: Pathologists. Lecture, April 15-19, 1985, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Fee:** $560. **Reg. Limit:** 90. **Credit:** Category 1, 47 hours. **Contact:** Robert J. Baker, M.D., Dean, (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Urology

Specialty Review in Urology
For: Urologists. Lecture, April 22-27, 1985, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Fee:** $610. **Reg. Limit:** None. **Credit:** Category 1, 53 hours. **Contact:** Robert J. Baker, M.D., Dean, (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Surgery

Fiberoptic Colonoscopy
For: Surgeons. Lecture, April 24-26, 1985, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Fee:** $490. **Reg. Limit:** 20. **Credit:** Category 1, 15 hours. **Contact:** Robert J. Baker, M.D., Dean, (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Fiberoptic Esophagogastric Endoscopy
For: Surgeons. Lecture, April 29-May 1, 1985, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Fee:** $490. **Reg. Limit:** 15. **Contact:** Robert J. Baker, M.D., Dean, (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Radiology

Specialty Review in Radiology
For: Radiologists. Lecture, April 8-12, 1985, Chicago,

Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Fee:** $550. **Reg. Limit:** 90. **Credit:** Category 1, 40 hours. **Contact:** Robert J. Baker, M.D., Dean, (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Surgery

Current Advances in Maxillofacial Reconstruction
For: Physicians, Oral Surgeons. Lecture, April 28, 1985, 8:00 to 4:00, Albert Sandel Auditorium, Edgewater Hospital, 5700 N. Ashland Avenue, Chicago, Illinois. **Sponsors:** Edgewater Hospital-Mazel Medical Center and Michael Reese Hospital and Medical Center. **Fee:** None. Lunch will be served. Reservations requested. **Credit:** Category 1, 6 hours. **Contact:** Patricia Keady. **Phone:** 878-6000, Ext. 385.

MAY

Allergy

Annual Alan Feinberg Resident-Fellow Program, May 20, 1985, 8:00 p.m.
For: Primarily Allergists. Lectures, Holiday Inn Chicago City Centre. **Sponsor:** Illinois Society of Allergy and Clinical Immunology, 800 East Northwest Highway #101, Mount Prospect, Illinois 60056. **Fee:** $15.00 dinner. **Limit:** None. **Credit:** Category 1, 1 hour. **Contact:** Dianne K. Kubis. **Phone:** 312/255-1024.

Dermatology and Allergy Symposium.
For: Physicians, Surgeons, Staff. Symposium, May 15, 1985, 1:00-5:20 p.m. Nashville, Illinois. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, Illinois 62708. **Fee:** $45.00. **Credit:** Category 1:4 hours, AAFP Prescribed: 4 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** 217/236-7711.

Anesthesiology

Specialty Review in Anesthesiology
For: Anesthesiologists. Lecture, May 12-17, 1985, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Fee:** $670. **Reg. Limit:** None. **Credit:** Category 1: 54 hours. **Contact:** Robert J. Baker, M.D., Dean, 800/621-4649 in Illinois; 800/621-4651 outside Illinois.

Cardiology

Coronary Artery Disease and Sudden Death; Primary and Secondary Prevention.
For: Primary Care Audience. Workshop/Lecture, May 3-5, 1985. Chicago—Hyatt Woodfield Hotel. **Sponsor:** International Medical Education Corporation, 64 Inverness Drive East, Englewood, Colorado 80112. **Fee:** $295.00. **Limit:** 75. **Credit:** Category 1: 13 hours; AAFP Prescribed: 13 hours; AOA: 13 hours. **Contact:** Beverly Jacobsen. **Phone:** 800/525-8651, extension 273.

Diagnosis and Treatment of Thromboembolic Disease, 1985 Conference, May 16, 17, 18.
For: Physicians in patient care. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Building, 610 Walnut Street, Madison, Wisconsin 53705. **Fee:** N/A **Limit:** None. **Credit:** CEU's: 10 hours, Category 1: 10 Hours. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** 608/263-2856.

Second Biennial Chicago Cardiovascular Symposium.
For: All Physicians. Course, May 8-10, 1985. Chicago, Illinois. **Sponsor:** American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104. **Fee:** N/A **Limit:** N/A **Credit:** Category 1: 15 hours. **Contact:** Maxine Topping, Section Chief. **Phone:** 215/243-1200.

Critical Care Medicine

14th Annual SCCM Educational and Scientific Symposium May 21-25, 1985
For: Critical Care Physicians, Nurses, Therapists and Scientists. **Sponsor:** Society of Critical Care Medicine, 223 East Imperial Highway, Suite 110, Fullerton, California 92635. **Fee:** Non-Member Physicians $375; Nurses and Therapists $270; Member Physicians $275; Member Nurses and Therapists $225. **Limit:** None. **Credit:** Category 1 up to 40 hours. **Contact:** Tracy Schultz, **Phone:** 714/870-5243.

Family Medicine

Specialty Review in Family Practice
For: General and Family Practitioners. Lecture, May 28-June 8, 1985, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Fee:** $725. **Reg. Limit:** 90. **Credit:** Category 1: 91 hours. **Contact:** Robert J. Baker, M.D., Dean, 800/621-4649 in Illinois; 800/621-4651 outside Illinois.

Obstetrics/Family Medicine

Controversies in Family Medicine/Low Intervention Obstetrics
For: Family Practitioners, Obstetricians, Obstetrics Nurses, Nurse Practitioners, Physician Assistants. Conference, May 21-23, 1985. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut Street, Madison, Wisconsin, 53705. **Co-Sponsor:** Department of Family Medicine and Practice, School of Medicine, University of Wisconsin. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 11 hours; Other: University of Wisconsin-Extension CEUs: 11 hours; AAFP Prescribed: 11 hours; AOA: 11 hours. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** 608/263-2856.

Plastic Surgery

Plastic Surgery in Primary Care
For: Primary Care and Emergency Physicians. Conference, May 17, 1985, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut Street, Madison, Wisconsin, 53705. **Co-Sponsor:** University of Wisconsin School of Medicine; Division of Plastic Surgery. **Fee:** $140, MD, DO. **Reg. Limit:** None. **Credit:** Category 1: 6 hours; AAFP Prescribed: 6 hours; AOA: 6 hours. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** 608/263-2856.

Pathology

Modern Methods of Diagnosis in Tumor Pathology, Slide Seminar.
For: Pathologists. May 13, 1985, 7:00 p.m. Drake Hotel, Chicago, Illinois. **Sponsor:** Chicago Pathology Society. **Fee:** For dinner. **Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall H. Short, M.D., Loretto Hospital, 645 South Central Avenue, Chicago, Illinois.

Pediatrics

Specialty Review in Pediatric Cardiology
For: Pediatric Cardiologists. Lecture, May 28-31, 1985, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Fee:** $475. **Reg. Limit:** 90. **Credit:** Category 1: 32 hours. **Contact:** Robert J. Baker, M.D., Dean, 800/621-4649 in Illinois; 800/621-4651 outside Illinois.

Psychiatry

Comprehensive Psychiatry Review Part II: The Psychiatric Interview.
For: Psychiatrists. Course, May 17-19, 1985. Chicago, Illinois. **Sponsor:** The University of Chicago, 5841 South Maryland, Box 139, Chicago, Illinois 60637. **Fee:** $375.00. **Limit:** None. **Credit:** Category 1: 17 hours. **Contact:** Mary Ann Dillon. **Phone:** 312/962-1056.

Surgery

Flexible Fiberoptic Sigmoidoscopy
For: Surgeons. Lecture, May 4, 1985, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Fee:** $145. **Reg. Limit:** 75. **Credit:** Category 1: 7 hours. **Contact:** Robert J. Baker, M.D., Dean, 800/621-4649 in Illinois; 800/621-4651 outside Illinois.

Advances in Surgery
For: General and Specializing Surgeons. Lecture, May 6-10, 1985, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Fee:** $540. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D., Dean, 800/621-4649 in Illinois; 800/621-4651 outside Illinois.

Hair Replacement Surgery
For: Surgeons. May 15-19, 1985. **Sponsor:** Northwestern University Medical School. **Fee:** $675.00. **Contact:** J.B. Pinski, M.D., 55 East Washington Street, Chicago, Illinois, Suite 3404.

Neuroradiology

1985 Neuroradiology Review Course
For: General Radiologists, Neuroradiologists, Neurosurgeons, Neurologists, Residents. Course, May 4-5, 1985, Oakbrook Marriott Hotel, Oak Brook, Illinois. **Sponsor:** Loyola University Medical Center, 2160 South First Avenue, Maywood, Illinois 60153. **Co-Sponsors:** Linda K. Gunzburger, Ph.D., Dept. of CME; Behrooz Azar-Kia, M.D., Dept. of Radiology. **Fee:** $170/$100 for Residents. **Credit:** Category 1: 16 hours. **Contact:** Linda K. Gunzburger, Ph.D. **Phone:** 312/531-3237.

JUNE

Oncology

Controversies in Breast Cancer Treatment
For: Oncologists/Radiation Therapists/Surgeons/Family Practitioners. Course, June 12, 1985, Holiday Plaza Complex, Matteson, Illinois. **Sponsor:** The University of Chicago, 5841 S. Maryland Avenue, Box 139, Chicago, Illinois, 60637. **Fee:** $20. **Reg. Limit:** None. **Credit:** AAFP Elective: 6 hours; AMA Category 1: 6 hours. **Contact:** Marlene Goldberg, Conference Manager. **Phone:** 312/962-1056.

Obstetrics/Gynecology

Chicago Area Medical Schools Review Course in Obstetrics and Gynecology
For: Gynecologists. Course, June 10-15, 1985, Chicago, Illinois. **Sponsor:** The University of Chicago, 5841 South Maryland—Box 139, Chicago, Illinois, 60637. **Fee:** TBD. **Credit:** Category 1: 32 hours; Other: ACOG: 32 hours.

Pathology

Flow Cytometry and Immunohistochemistry in Diagnosis of Hematologic Malfunction
For: Pathologists. Symposium, June 10, 1985, Drake Hotel, Chicago, Illinois. **Sponsor:** Chicago Pathology Society, Marshall H. Short, M.D., Loretto Hospital, 645 S. Central Avenue, Chicago, Illinois, 60644. **Co-Sponsor:** Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall H. Short, M.D. **Phone:** 312/626-4300, Ext. 5720.

Pharmacology

Prediction of Drug Levels and Drug Monitoring
For: Primary Care Practitioners. Conference, June 6-7, 1985, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut Street, Madison, Wisconsin, 53705. **Co-Sponsor::** University of Wisconsin, School of Medicine, Department of Medicine; University of Wisconsin Hospitals and Clinics. **Reg. Limit:** None. **Credit:** Category 1: 12 hours; Other: University of Wisconsin-Extension CEU's; AAFP Prescribed: TBD hours; AOA: TBD hours. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** 608/263-2856.

Surgery

Medical and Surgical Review of Reflux Esophagitis and the Angelchik Prosthesis
For: Surgeons, Primary Care Physicians. Conference, June 14-15, 1985, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut Street, Madison, Wisconsin. **Co-Sponsor:** University of Wisconsin, School of Medicine, Department of Surgery. **Fee:** $200. **Reg. Limit:** None. **Credit:** Category 1: 11 hours; Other: University of Wisconsin-Extension CEU's. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** 608/263-2856.

Relaxation/Fitness

Corporate and Industrial Wellness
For: M.D.'s, R.N.'s, O.T.'s, Administrators, Dietitians and Health Care Professionals. Workshop, June 10-13, 1985, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Philip K. Wilson, Ed. D., La Crosse Exercise Program, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse, Wisconsin, 54601. **Co-Sponsor:** La Crosse Lutheran Hospital/Gundersen Clinic, Ltd. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; Other: 3.5 CEU's from Community Health, UW-La Crosse, Extended Education/UWEX; AAFP Prescribed: 35 hours.

Teaching Stress Management and Relaxation Skills
For: M.D.'s, R.N.'s, P.T.'s, O.T.'s, Administrators and Dietitians. Workshop, June 2-7, July 14-19, November 10-15, 1985, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Room 221 Mitchell Hall, University of Wisconsin-La Crosse, La Crosse, Wisconsin, 54601. **Co-Sponsor:** La Crosse Lutheran Hospital/Gundersen Clinic, Ltd. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; Other: 3.5 CEU's from Community Health, UW-La Crosse, Extended Education/UWEX; AAFP Prescribed: 35 hours.

Fitness and Weight Control
For: M.D.'s, R.N.'s, P.T.'s, O.T.'s, Administrators, Dietitians and other Health Care Professionals. June 3-7, July 22-26, 1985. **Sponsor:** La Crosse Exercise Program Education Services Unit, Room 221 Mitchell Hall, University of Wisconsin-La Crosse, La Crosse, Wisconsin, 54601. **Co-Sponsor:** La Crosse Lutheran Hospital/Gundersen, Ltd. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; Other: 3.5 CEU's from Community Health, UW-La Crosse, Extended Education/UWEX; AAFP Prescribed: 35 hours.

Society of Critical Care Medicine Presents its 14th Annual Symposium



Hyatt Regency Chicago May 21-25, 1985

CONTINUING EDUCATION UNITS have been approved by the Council for Continuing Medical Education (ACCME) Category I.
CCM SUBSPECIALITY EXAM Critical Care Self Assessment Program VI (CCSAP VI) will be given on Tuesday, May 21. Discussion of the results, answers and rationales will be given on saturday, May 25.

DISCOUNT AIRFARES of 40-45% available through AIR TRAVEL SERVICE; call toll-free at (800) 241-5644.
SPOUSES TOURS of Chicago's highlights will be offered by CHICAGO IS . . . INC.
VOLUME 6 of CRITICAL CARE STATE OF THE ART will be the syllabus for plenary lectures.

REGISTRATION FORM

YES, I WANT TO ATTEND THIS IMPORTANT MEETING

REGISTRATION FEE INCLUDES TEXTBOOK, SPECIAL EVENING FUNCTIONS (Not applicable to daily registrants)

SCCM MEMBERS	MAIL REGISTRATION	ON-SITE	DAILY** (ON-SITE ONLY)
Physicians	$275	$325	$85
Nurses, Allied Health Personnel Associate Members	$225	$275	$60
NON MEMBERS			
Physicians Intern*, Residents,* Fellows*, Nurses, and Allied Health Personnel	$375	$425	$110
	$270	$320	$70
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*Requires verification letter
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REFUND REQUEST MUST BE MADE IN WRITING
Up to April 30, 1985—full refund less $50 processing fee.
Up to May 10, 1985—50% refund.
Mail registration must be received by May 10, 1985

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MAIL CHECK TO: SCCM
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Symposium registration $ _____
Spouse registration $ _____
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IMJ

PRELIMINARY CONTENT

PLENARY LECTURERS

Economic Issues; Critical Care Medicine in the 80's
Jeffrey A. Augenstein, MD, PhD
Pre-Operative Pulmonary Function Testing
Philip G. Boysen, MD
The Ventilator Dependent Patient: Medical & Social Care
Robert G. Kettrick, MD
Positive Airway Pressure: System Design & Clinical Application
Robert R. Kirby, MD
Treatment of Acute Myocardial Infarction, 1985
Charles Rackley, MD
Brain Resuscitation: 'Fact or Fancy'
Harvey M. Shapiro, MD
Transplantation
Thomas E. Starzl, MD, PhD
Management of Pain & Pain Related Problems in the Critically Ill Patient
Theodore H. Stanley, MD
Hypertensive Crisis in Critical Care
W. Leigh Thompson, PhD, MD
Trauma Critical Care Units: What Price Salvage?
Alexander Walt, MD

HEMODYNAMIC MONITORING WORKSHOP

PANELS

Critical Care Medicine and Nursing — Practice, Problems and Solutions
Frank H. Gafford, IV. MD, Chairman
Management of Critically Ill - Immunocompromised Patients
Joseph E. Parrillo, MD, Co-Chairman
Henry Masur, MD, Co-Chairman
Uniformed Services Scientific Section
Robert W. Taylor, MD, Head of Section
Cellular Mechanism of Acute Lung Injury: A Basis for Future Therapy for ARDS
Jean E. Rinaldo, MD, Chairman
Industry: a) Impact of DRG's on . . .W. Leigh Thompson, PhD, MD
b) Impact of Product Liability on . . . David Swedlow, MD
Judy Snyderman, MBA, Chairman
Does an Ounce of the Right Pre-Hospital Care Save a Ton of ICU Care — Which Interventions Really Make a Difference?
Paul E. Pepe, MD, Chairman
Critical Care Research – Asking the Right Question
Joseph M. Civetta, MD, Chairman
Critical Care Research – How to Answer the Question
Bart Chernow, MD, Chairman
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All proposed advertisements should be received by the tenth of the month preceding publication. A surcharge of $2 will be assessed when a box number is requested.

POSITIONS AND PRACTICE

MEDICAL DIRECTOR. Opportunity for physician with experience in medical group practice administration to join established HMO in Madison, Wisconsin. Group Health serves 29,000 patients with its staff of 20 physicians and total staff of 180. Excellent salary and benefit program. This represents a rewarding opportunity to develop or progress your career in medical administration. Contact: John Mueller, Group Health Cooperative, 1 South Park St., Madison, WI 53715; phone 608-251-4156.

ANTERIOR SEGMENT FELLOWSHIP in busy private practice associated with Medical College. Intraocular Lens Implantation, including posterior chamber and anterior chamber lenses. Extracapsular and Phacoemulsification techniques. Argon & Yag Laser. Excellent benefits plus fringes. Send CV and career objectives to Box #1139, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

EXCELLENT OPPORTUNITY for family physician to join growing northside medical group. Equity position in medical corporation available. No OB or Surgery. Membership on university affiliated hospital staff assured. Compensation $60,000 including benefits. Reply with resume to Box #1143, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

MULTI-SPECIALTY GROUP thirty miles southwest of Chicago seeks board eligible obstetrician-gynecologist to join expanding practice. Incentive plan, profit-sharing, relatively new building. Excellent practice opportunity with above average grade and high schools. Contact Howard Osmus, Administrator, Hedges Clinic, Frankfort, IL 60423, (815-469-2123).

GENERAL PRACTICE for sale or lease in Central Illinois, growing community, well established, near modern hospital. Solo-coverage available. Will help get established. From $150,000/year. Fully equipped, own building. Reasonable terms. Reply to Box #1146, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

GENERAL/FAMILY PRACTITIONERS If you are looking for an opportunity to be in the forefront of medical care, practice preventive medicine, work with other innovative professionals, and earn a comfortable living in pleasant surroundings, send your curriculum vitae to Physician Placement Dept-24. An equal opportunity employer. CIGNA Healthplans of California, 700 N. Brand Blvd., Ste 500, Glendale, CA 91203.

WANTED: MEDICAL OPHTHALMOLOGIST, Illinois: Partnership/association/locum tenens/sale of practice. Surgical assistance, glaucoma, refractions and laser important. Established practice, low overhead setting with excellent hospital. New facility in planning stages with great opportunity to develop tax advantages. Write Box #1152, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

INTERNIST—BC/BE with or without subspecialty to join well established group in midwest community near Chicago. Excellent salary and benefits first year with partnership second. Send CV to Frank H. Descourouez, M.D., President, Freeport Medical Clinic, Ltd., 750 S. Kiwanis Drive, Freeport, Illinois 61032. Telephone 815/235-6131.

EMERGENCY MEDICINE—Illinois and Missouri. Full and part time positions available in emergency departments and clinics for qualified physicians seeking lucrative employment opportunities. Outstanding remuneration and comprehensive malpractice insurance provided. For further information contact Amy Eisenman, Staffing Specialist. National Emergency Services, Inc., 1 Hollow Lane, Suite 304, Lake Success, New York 11042 or call (800) 645-4848.

ENT—BOARD CERTIFIED/ELIGIBLE part-time initially with large multispecialty west suburban Chicago group (private practice/HMOs). Income based on production. Send CV to Box #1158, c/o the *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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OPHTHALMOLOGIST AND ENT physician wanted part time for busy office. This is an unusual opportunity with excellent potential. South suburban Chicago area. Call 312-598-3131.

U.S. AIR FORCE MEDICAL CORPS currently is accepting applications for physicians in the following specialties: Surgery (all specialties), Obstetrics/Gynecology, Otorhinolaryngology, Anesthesiology, Psychiatry, Orthopedic Surgery, Cardiology, Allergist, Family Practice, and Internal Medicine. For further information call collect: Captain Brian Legg, (312) 263-1207.

CARDIOLOGIST—Board eligible/certified cardiologist needed. Should be proficient in catherization and implantation of permanent and temporary pacemakers. Both invasive and non-invasive experience preferred. For information, call Donald B. Dawson, Director of Physician Staffing, toll-free at 1-800-446-2255, in California call 1-800-336-2255. For opportunities in Utah call Maryalys Poulson collect at 801-355-1234. FHP Professional Staffing, 400 Oceangate Blvd., Ste. 1317, Long Beach, CA 90802.

FHP IS SEEKING an orthopedic surgeon who has completed or is currently involved in a total arthroplasty fellowship, or an orthopedic surgeon with extensive experience in total joint replacement with particular reference to revision arthroplasty. For information, call Donald B. Dawson, Director of Physician Staffing, toll-free at 1-800-446-2255, in California call 1-800-336-2255. For opportunities in Utah call Maryalys Poulson collect at 801-355-1234. FHP Professional Staffing, 400 Oceangate Blvd., Ste. 1317, Long Beach, CA 90802.

INTERNAL MEDICINE: Full-time opportunities available for board eligible or board certified physicians for busy inpatient internal medicine department of south Florida hospital. Clinic positions also available in Tampa, Palm Beach and Miami. Send C.V. to Fern Blum, EMSA, 8200 W. Sunrise Blvd, Building C, Plantation, Florida, 33322 or call 305/472-6922.

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AN EXCELLENT OPPORTUNITY for an OB/GYN to join a strong group practice in a beautiful lakefront city in eastern Wisconsin. Enjoy an outstanding quality of life within an easy commute to major metropolitan areas. Reply in confidence to: Director of Physician Recruitment, Recruitment Consultants, 400 Renaissance Center, Suite 500, Detroit, Michigan 48243 (313) 259-2000.

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FAMILY PRACTITIONER—for multispecialty medical building in Valparaiso, Indiana. Large referral base. Opportunity for lab and X-ray partnership and new building depreciation or lease. Contact Thomas Covey, M.D. (219) 462-4167 for details.

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GENERAL INTERNIST—for multispecialty medical building in Valparaiso, Indiana. Large referral base. Opportunity for lab and X-ray partnership and new building depreciation or lease. Contact Thomas Covey, M.D. (219) 462-4167 for details.

ASSISTANT DIRECTOR/PULMONARY Our client, a major pharmaceutical company is seeking a board eligible/certified physician with private practice or academia experience to conduct clinical trials for new drugs. Send CV to Bruce Rogers Co. Management Consultants, 20 Main Street, Port Washington, N.Y. 11050, (516) 883-1058.

FAMILY PRACTITIONER—Out patient care. Full-time position available for residency trained, board eligible/board certified family practitioner interested in a position involving out-patient care. Pediatrics, pre-natal care, adult medicine, orthopedics and minor surgery responsibilities are available. For information, Call Donald B. Dawson, Director of Physician Staffing, toll-free at 1-800-446-2255, in California call 1-800-336-2255. For opportunities in Utah call Maryalys Poulson collect at 801-355-1234. FHP Professional Staffing, 400 Oceangate Blvd., Ste. 1317, Long Beach, CA 90802.

OB/GYN—for multispecialty medical building in Valparaiso, Indiana. Large referral base. Opportunity for lab and X-ray partnership and new building depreciation or lease. Contact Thomas Covey, M.D. (219) 462-4167 for details.

FAMILY PRACTICE opportunities exist with several expanding Marshfield Clinic, hospital-affiliated satellites in north central Wisconsin. The board certified/board eligible candidate will share the philosophy of oriented care with a preventive focus, enjoy the support of over 200 physician and surgeon specialists, and live at the doorstep of year round recreational activities. Marshfield Clinic offers an excellent salary and benefit program including a liberal vacation and education leave. Please send curriculum vitae to: John P. Folz, Assistant Director, 1000 North Oak, Marshfield, Wisconsin 54449.

SITUATIONS WANTED

PHYSICIANS DESIRE RELOCATION. Husband, family practice and general surgery; wife OB/GYN and anesthesiology, desire practice opportunity in community of 5000 with small hospital. Write to Box #1119, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

ILLINOIS LICENSED PHYSICIAN certified in Pathology and Nuclear Medicine. Over 30 years experience. Residing in Israel. Available for vacation coverage 1-2 months per year. Reply to Box #1153, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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MEETING ANNOUNCEMENT August 10-16, 1985. 10th International Congress of Hypnosis and Psychosomatic Medicine, introductory and specialized workshops and scientific program. Toronto, Ontario, Canada. Information—10th International Congress Secretariat, 200 St. Clair Avenue West, Suite 402, Toronto, Ontario, Canada, M4V 1R1

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SORBITRATE®
(ISOSORBIDE DINITRATE)

Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks. Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis.

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites. Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established. If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension.

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE. The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy.

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary.

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur. Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory. The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined. However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals. On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months.

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers. In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal. The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly.

Information for Patients: Headache may occur during initial therapy with SORBITRATE. Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use.

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates.

Isosorbide dinitrate acts directly on vascular smooth muscle; therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug. A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet.

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose. There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman.

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established.

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related. In clinical trials at various doses, the following have been observed:

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent. Cutaneous vasodilation with flushing may occur. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur. Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg; for oral (swallowed) tablets, 5 to 20 mg; and for controlled-release forms, 40 mg.

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose. In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure.

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours. Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported.

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended. The extent to which development of tolerance should modify the dosage program has not been defined. *The oral controlled-release forms of isosorbide dinitrate should not be chewed.*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg); Chewable Tablets (5, 10 mg); Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg).

STUART PHARMACEUTICALS
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Wilmington, DE 19897

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Another Milestone . . . and the Future



As I come to the end of my presidential year, I look back on some accomplishments, but, more important, I look to the near future with a great deal of enthusiasm.

It has been a real privilege to meet with and be entertained by the many county societies I visited throughout our state. Personal visits corroborated the polls: malpractice *is* the most important problem facing Illinois physicians today. Our professional liability initiative has answered not only the question, "What is ISMS doing about it?" but also, "What can we, as individuals, do?" The response has been gratifying and will be effective. Action teams have been formed; meetings with legislators and community groups are taking place with greater frequency. State senators and representatives, although they may be influenced by lobbyists and personal situations, must listen to and act favorably upon the desires of their constituents if they expect to remain in office. The time is *now* to continue and increase our efforts.

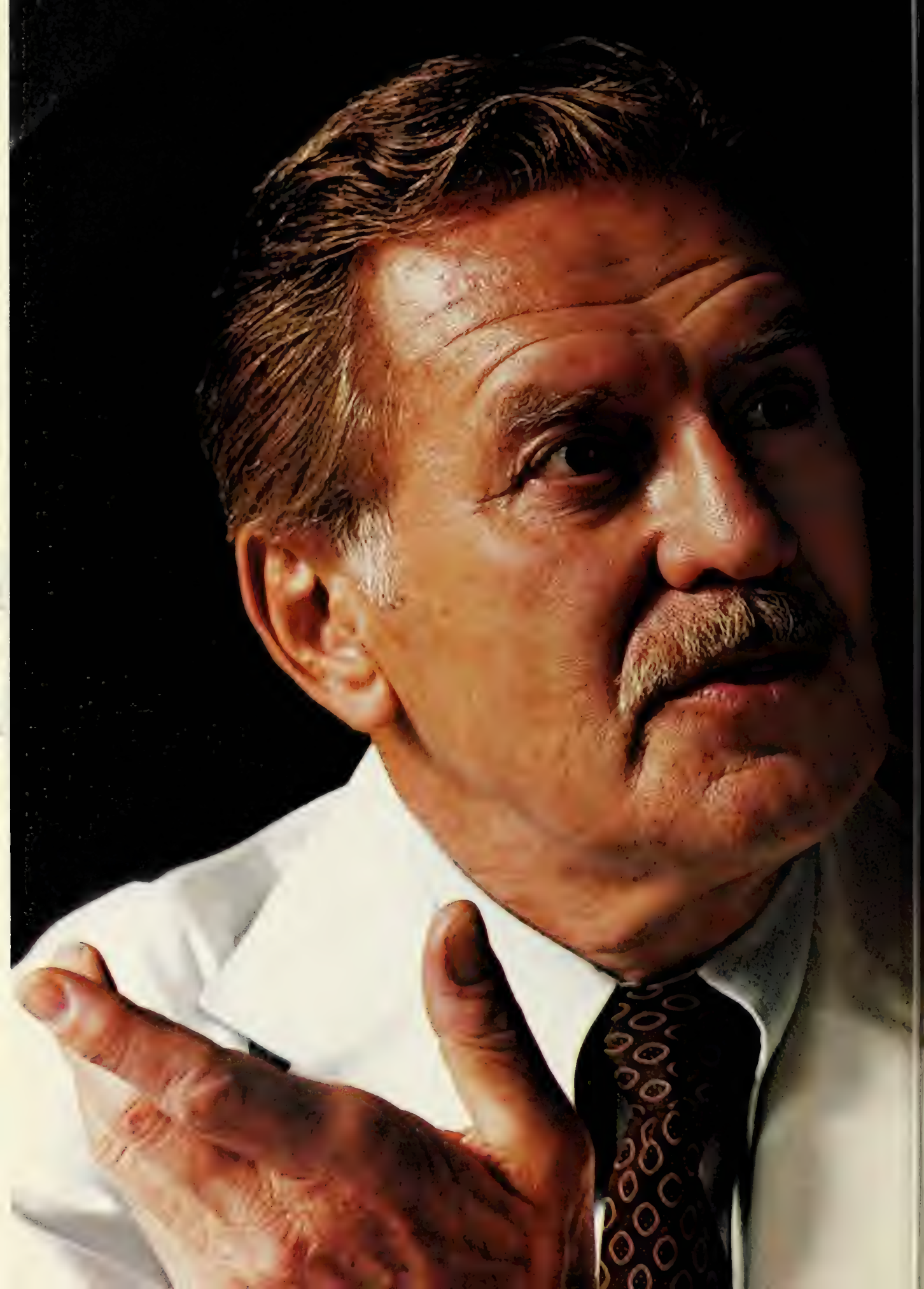
After years of protracted and expensive ($500,000) litigation, and the prospects of equaling both in the future, ISMS has settled out of the Wilk chiropractic suit. Only national organizations, including the AMA, of which we are all members, now remain in the suit. I would ask you *carefully* to read the statement elsewhere in this issue. It emphasizes freedom of choice; it is not a mandate to individual physicians. The best interest of each of our patients must still be paramount.

Although a decision will probably be long in coming, the discriminatory Medicare fee freezes and participation agreements are being argued in Congress and the courts—on a national level—by the AMA. Our united support is essential for just and fair resolution of these disputes. We must continue to be involved and represented on all levels of government—national, state, county, and city. Our delegation to the AMA, incidentally, was instrumental in obtaining both financial and other recognition from the AMA for our unified status.

I am indebted to the other officers, the staff, and my fellow members for all their help and support this past year. To them goes the credit for the successes of our Society; I accept the responsibility for the failures, for *it happened on my watch.*



Robert C. Hamilton, M.D.
President



"When it comes to cardiovascular medicine, I like to know exactly what my patients are swallowing."

There are doctors who say that generic drugs have a place in their practice—but not necessarily in the treatment of serious or potentially life-threatening disease. And when they consider that the average patient pays only about 45¢ a day for INDERAL (propranolol HCl) Tablets, there's not much left to discuss.

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Please see next page for brief summary of prescribing information.



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10 mg 20 mg 40 mg 60 mg 80 mg 90 mg*

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL® (propranolol hydrochloride) Tablets

CONTRAINDICATIONS

INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL

WARNINGS

CARDIAC FAILURE. Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL, like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA. Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS. Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS

General: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL (propranolol hydrochloride) may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

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Ask any other carrier what they're giving you for your premium dollars. Then call the Exchange and ask about the Exchange's malpractice initiative and its protection program. Then compare. You'll see that no other carrier measures up to the Exchange.

Illinois State Medical Inter-Insurance Exchange

Twenty North Michigan Avenue, Suite 700 / Chicago, Illinois 60602
(312) 782-2749 800-782-ISMS (toll-free)

Expressing Opinion in Print

Confronting the Issues in the Public Media

Action teams across the state have worked to bring the professional liability initiative to the attention of the public. Three effective means are "op/ed" features, letters to the editor and editorial endorsements.

Visibility is a key to legislative success. Physicians can work with the media to increase awareness and understanding among members of the public and their elected representatives. Malpractice reform is a complex issue and the printed word is one of the best educators.

Op/Ed Columns and Letters to the Editor

Opinion/editorial pieces and letters to the editor serve several purposes. They educate and raise interest levels. They bring the item to the attention of community leaders and journalists. They maintain an awareness of the matter at issue.

Dr. Fredrick Heinzen, Peoria County Medical Society president, submitted an op/ed article to the *Peoria Journal Star.* His feature ran side by side with an op/ed from a prominent trial attorney in the March third edition. The articles showed pro and con arguments about the ISMS/ISMIE legislative proposals.

A regular exchange between local physicians and lawyers has been published almost daily in the *LsSalle Daily News Tribune.*

Activities like these will start people and their legislators thinking. They can engender the support that's needed to pass legislative reforms.

Editorial Endorsements

Members of the media are beginning to acknowledge the impact of frivolous lawsuits on health care costs. Editorials addressing the problem of excessive malpractice litigation have appeared in *USA Today,* the *Quad City Times,* the *Aurora Beacon-News,* the *Belleville News Democrat,* the *Chicago Tribune* and the *Chicago Sun Times.*

Several action teams have already sought editorial endorsements. In Danville and Springfield, action teams have appeared before local editorial boards to present legislative proposals. In each instance, local attorneys had made a previous presentation.

To assure maximum impact, it is recommended that action teams seek editorial endorsements as soon as the legislation is introduced.

(Continued on page 272)



Members of the Cook County Physicians Association listen to addresses by local legislators at Provident Hospital in Chicago.

Angina comes in many forms...

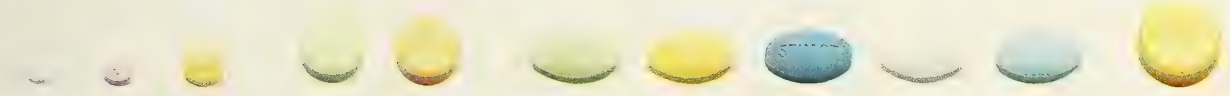


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(ISOSORBIDE DINITRATE)

Unsurpassed flexibility in nitrate therapy.



2.5 mg 5 mg 10 mg
Sublingual Tablets

5 mg 10 mg
Chewable Tablets

5 mg 10 mg 20 mg 30 mg 40 mg
Oral "Swallow" Tablets

40 mg
Sustained Action "Swallow" Tablets

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See following page for brief summary of prescribing information.

SORBITRATE®
(ISOSORBIDE DINITRATE)

Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks. Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis.

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites. Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established. If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension.

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE. The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy.

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary.

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur. Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory. The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined. However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals. On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months.

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers. In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal. The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly.

Information for Patients: Headache may occur during initial therapy with SORBITRATE. Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use.

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates.

Isosorbide dinitrate acts directly on vascular smooth muscle; therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug. A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet.

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose. There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman.

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established.

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related. In clinical trials at various doses, the following have been observed:

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent. Cutaneous vasodilation with flushing may occur. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur. Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg; for oral (swallowed) tablets, 5 to 20 mg; and for controlled-release forms, 40 mg.

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose. In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure.

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours. Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported.

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended. The extent to which development of tolerance should modify the dosage program has not been defined. *The oral controlled-release forms of isosorbide dinitrate should not be chewed.*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg), Chewable Tablets (5, 10 mg), Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg).

STUART PHARMACEUTICALS
Division of ICI Americas Inc.
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STR-2282

Professional Liability Initiative

(Continued from page 270)

Public Relations Workshops

Meetings for hospital public relations professionals working with action team members have been held across the state. The purpose is to assist efforts to generate news stories and editorial endorsements.

Thirty public relations professionals from Chicago area hospitals met on March seventh. Shirley Garrison, public relations director at Alexian Brothers Medical Center, briefed the group on use of press releases, posters and hospital newsletters for working within the hospital and with public groups. In a program designed to help these professionals generate media coverage of the malpractice issue, those present viewed the slide show, "Trivial Suit," and discussed approaches to working with the media.

The Illinois Hospital Public Relations Society, a component of the Illinois Hospital Association, produced a similar program at their Peoria regional meeting on March 11 at St. Francis Medical Center. Representatives from hospitals in Ottawa, Streator, Macomb, Peoria and Pekin attended the meeting, and similar gatherings are planned in other regions.

At the end of March, more than 235 audiences, including not only county medical societies and auxiliaries but also many public service groups had seen "Trivial Suit." More than 100 action teams had been formed, and many more were "under construction."

Meetings With Legislators

DuPage County action teams pooled forces to sponsor a massive physician/legislator meeting on March 25 at the Marriott Oak Brook. Member and non-member physicians were invited, along with 17 local senators and representatives. Physicians were able to meet in small groups and discuss the issues and proposals with their legislators. Media were invited to attend as well.

Members of the Cook County Physicians Association, a group of about 400 black physicians, met with local legislators and representatives of legislators at Provident Hospital on Chicago's South Side. Conducting the meeting were **Dr. Earl Fredricks** and ISMS President **Dr. Robert C. Hamilton.** Both television and newspaper coverage resulted from the event, as Chicago media were invited to interview participants at its conclusion.

Rally Scheduled

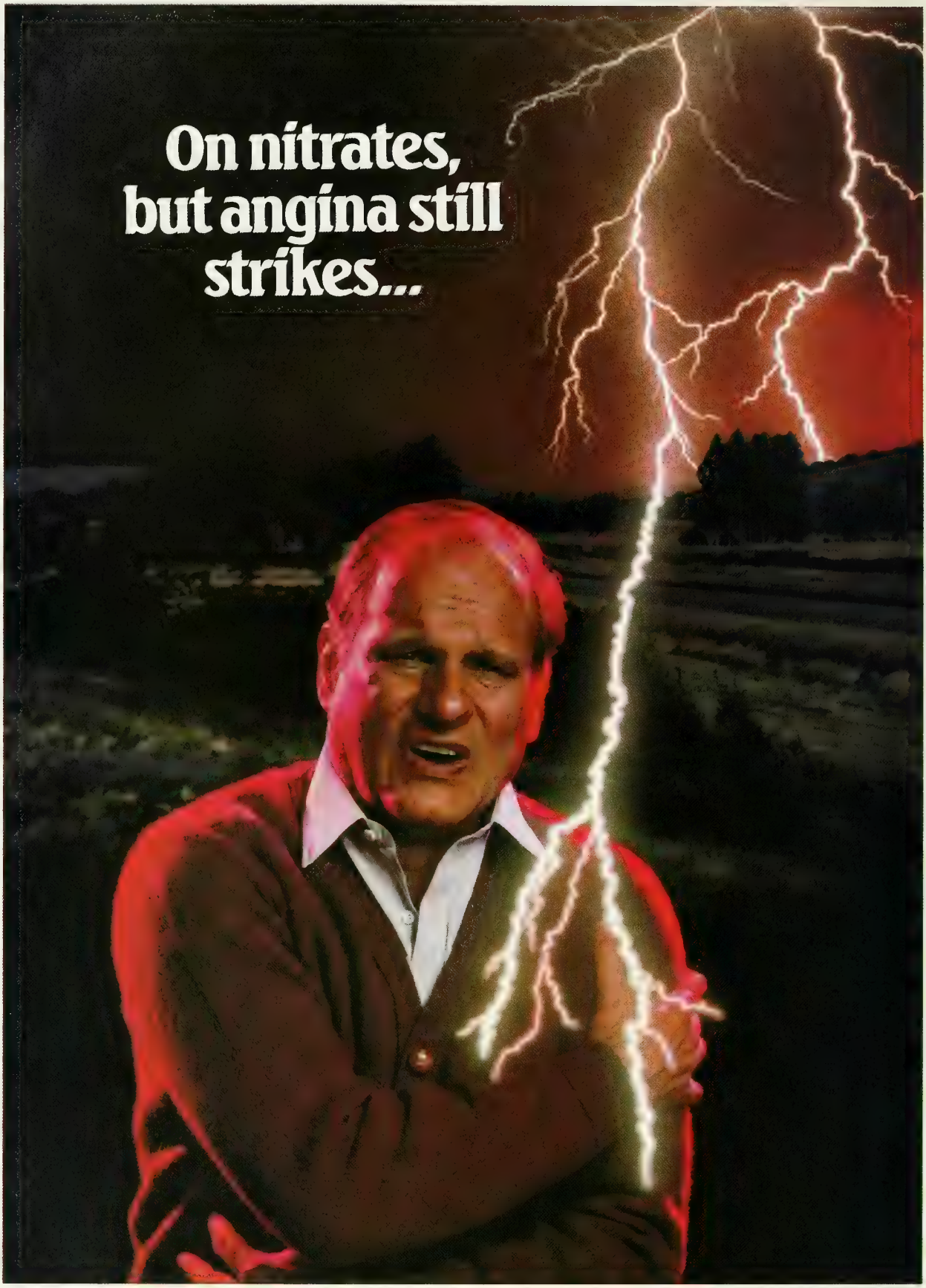
On May 22, ISMS will sponsor a rally for legislative reform in Springfield. Physicians are being asked to mark their calendars and plan to spend that day in Springfield, meeting with legislators to discuss the issues. More information on the rally will be forthcoming. ◀

Statement on Interprofessional Relations with Doctors of Chiropractic

The Illinois State Medical Society declares that, except as provided by law (statute or final judicial opinion), there are and should be no ethical or collective impediments to full professional association and cooperation between doctors of chiropractic and medical physicians. Individual choice by a medical physician voluntarily to associate professionally or otherwise cooperate with a doctor of chiropractic should be governed only by legal restrictions, if any, and by the individual medical physician's personal judgment as to what is in the best interest of a patient or patients.

Professional association and cooperation, as referred to above, includes, but is not limited to, referrals, consultations, group practice in partnerships, HMO's, PPO's, and other alternative health care delivery systems; the provision of treatment privileges and diagnostic services (including radiological and other laboratory facilities) in or through hospital facilities; working with and cooperating with doctors of chiropractic in hospital settings where the hospital's governing board, acting in accordance with applicable law and that hospital's standards, elects to provide privileges or services to doctors of chiropractic; association and cooperation in hospital training programs for students in chiropractic colleges under suitable guidelines arrived at by the hospital and chiropractic college authorities; participation in student exchange programs between chiropractic and medical colleges; cooperation in research programs and the publication of research material in appropriate journals in accordance with established editorial policy of said journals; participation in health care seminars, health fairs or continuing education programs; and any other association or cooperation designed to foster better health care for patients of medical physicians, doctors of chiropractic, or both.

* * *


On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®
(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin...for more comprehensive antianginal protection without side effects which may cramp an active life style.



ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN® TABLETS
(verapamil HCl/Knoll)
80 mg and 120 mg

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction <30%) or moderate to severe symptoms of cardiac failure. Control milder heart failure with optimum digitalization and/or diuretics before ISOPTIN is used. ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild, and controlled by decrease in ISOPTIN dose). Occasional elevations of liver enzymes have been reported; patients receiving ISOPTIN should have liver enzymes monitored periodically. Patients with atrial flutter/fibrillation and an accessory AV pathway (e.g., W-P-W or L-G-L syndromes) may develop a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion. AV block may occur (3rd degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema, and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with ISOPTIN. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, patients should be monitored closely. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function or in patients who have also recently received methyldopa. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patient carefully monitored. ISOPTIN may have an additive hypotensive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR<50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%). The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: confusion, paresthesia, insomnia, somnolence, equilibrium disorders, blurred vision, syncope, muscle cramps, shakiness, claudication, hair loss, maculae, and spotty menstruation. Overall continuation rate of 94.5% in 1,166 patients. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in 80 mg and 120 mg sugar-coated tablets. July 1982 2068

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Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal.* The *Journal,* however, will secure author permission before authorizing a reprint.

Anxiety Relief for the Patient Who Must Remain Alert[1-8]



Tranxene dramatically increased beta wave activity

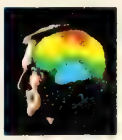
- relieved anxiety
- maintained alertness

In a double-blind randomized study of 20 patients with generalized anxiety disorder, patients treated with Tranxene showed marked improvement in Hamilton Anxiety Ratings, and dramatic increase in beta wave activity.[1] Beta wave activity is associated with concentration, attention, mental focusing.[1,9,10]

...plus Tranxene offers a time-proven profile of safety

The Tranxene safety record is backed by over 12 years of clinical success. There's little likelihood of problem sedation* with Tranxene, and adverse reactions such as withdrawal seizures and amnesia are unlikely to occur.

TRANXENE®
(clorazepate dipotassium) ©
Is Anxioselective™†



*Problem sedation is defined as moderate to severe degrees of sedation, sleepiness, drowsiness, or lassitude.

†Anxioselective refers to a drug whose most prominent action is anxiety reduction and which has less prominent other behavioral consequences.

For further details of this study, contact your Abbott representative.

Please see Brief Summary.

TRANXENE®
(clorazepate dipotassium) Ⓒ IV

Brief Summary of Prescribing Information

INDICATIONS—For management of anxiety disorders or short-term relief of symptoms of anxiety; for symptomatic relief of acute alcohol withdrawal; for adjunctive therapy in partial seizures.

Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic. Effectiveness in long-term management of anxiety (over 4 months) not assessed by systematic clinical studies. The physician should periodically reassess usefulness for each patient.

CONTRAINDICATIONS—Known hypersensitivity to the drug. Acute narrow angle glaucoma

WARNINGS—Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

Pregnancy and Lactation: Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

PRECAUTIONS—Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated

ADVERSE REACTIONS—Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure.

INTERACTIONS—Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors and other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

OVERDOSAGE—Take general measures as for any CNS depressant

SUPPLIED—TRANXENE 3.75, 7.5, and 15 mg capsules and scored tablets. TRANXENE-SD Half Strength 11.25 and TRANXENE-SD 22.5 mg single dose tablets.

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Physicians, Attorneys, Present Testimony

Members of the Governor's special task force on medical malpractice heard differing points of view as testimony from interested parties continued in February and March.

In a February 28 appearance, representatives of trial lawyer groups downplayed the seriousness of the malpractice problem. But a week later, several physicians testified that the malpractice crisis is real and has reached a point where they are quitting their medical practice or preparing to move to another state.

James F. Stack, president of the Illinois Trial Lawyers Association, disputed the existence of a crisis. Stack pointed to statistics indicating that malpractice premiums comprise only an average of 3.4% of a physician's gross income. He cautioned that the task force should not "look at an insurance premium in a vacuum," but rather in relation to income and risk. Maintaining that physicians and hospitals pass on the costs of malpractice to their patients, Stack said, "I suggest that if someone else is paying the premium, you have no crisis at all."

Stack conceded that physicians may have a legitimate complaint with respect to the large numbers of frivolous malpractice suits. But he criticized the legislative package proposed by the Illinois State Medical Society, saying it "would totally destroy the entire tort reparation system." The trial lawyers' association president said he "has a deep desire to seek out a solution to the problem of frivolous suits." But he maintained that solutions could be found that would not, "take away the rights of people." Stack also emphasized that true incidents of malpractice occur frequently. He described for the task force one such case, which had resulted in a verdict of $5.74 million.

Echoing Stack's comments, Chicago Bar Association President John D. Hayes said that the current system of compensation "has served the state well" and is not in need of an overhaul. However, Hayes agreed with Stack that too many frivolous law suits are being filed. Hayes maintained that one of the biggest problems was a "failure to deal with the insuring mechanism."

David A. Decker, ITLA's president-elect and a member of the Illinois State Bar Association's Board of Governors, told the task force that the ISBA unanimously supported a policy statement "to place responsibility" on attorneys in the area of frivolous suits. Also speaking for the ISBA was Daniel Houlihan, the association's legislative representative, who informed the task force that meetings were being held between representatives of the legal and medical community in an attempt to resolve the problem.

At its March 7 meeting, the task force heard from several physicians seriously affected by the malpractice situation. Dr. George Murphy, a Marion radiologist, told the task force that physicians "are now being held to a standard of perfection." He added that malpractice suits "aren't going against the bad apples. They're going against the doctors that take care of the sickest patients."

Dr. Dorothy Larson, a family practitioner from Mascoutah, told the task force that the malpractice situation was the reason she will quit her medical practice on May 1. Dr. Larson said she was sure her decision "will make quite a difference in (her patients') lives," but she emphasized that there is "a limited amount of emotional distress I can take." She recounted for the task force an instance in which a patient's family sued after the death

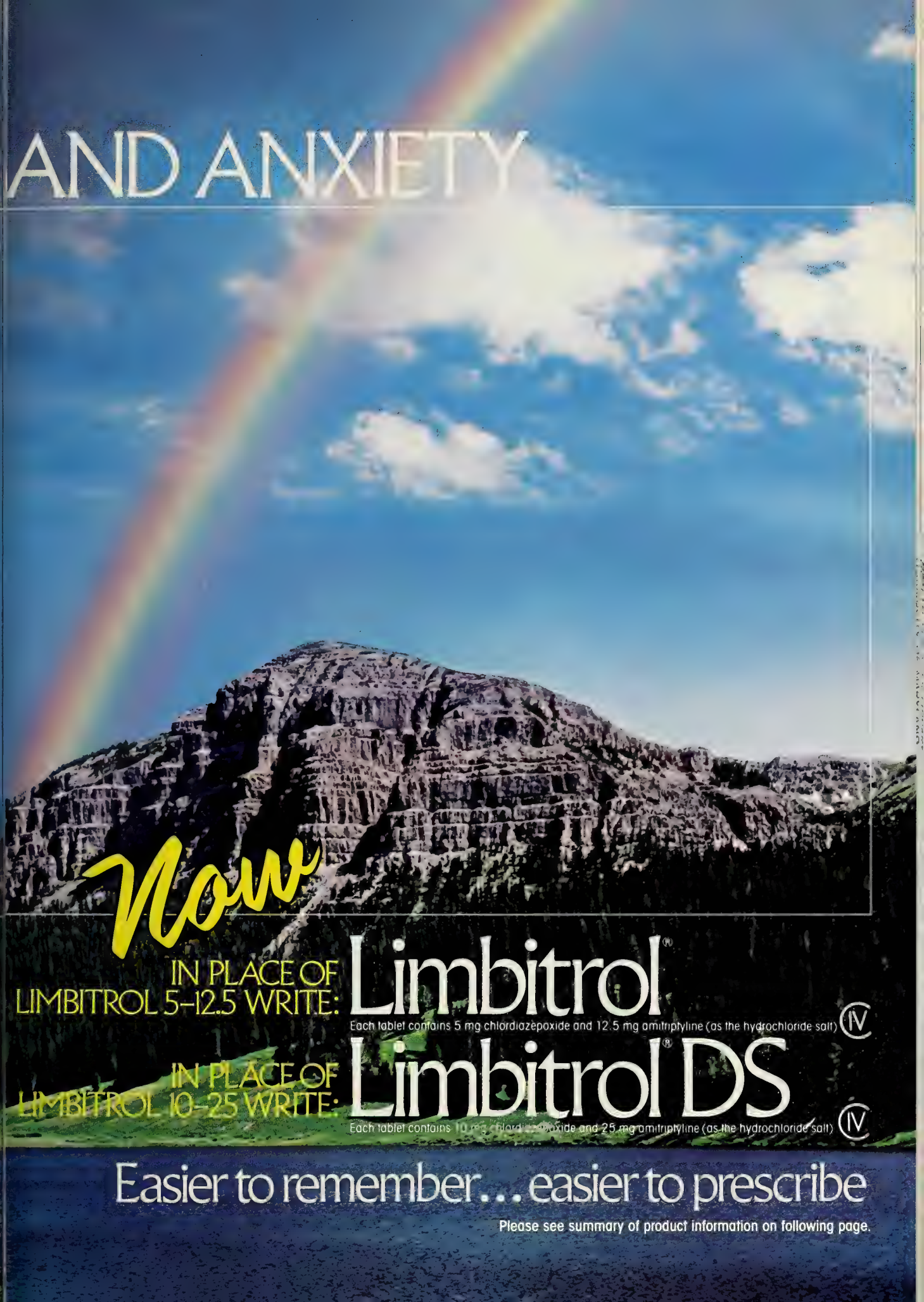
(Continued on page 282)

In moderate depression and anxiety

CLEARING: BOTH DEPRESSION...



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AND ANXIETY
Now
IN PLACE OF
LIMBITROL 5-12.5 WRITE:
Limbitrol®
Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
IV
IN PLACE OF
LIMBITROL 10-25 WRITE:
Limbitrol® DS
Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)
IV
Easier to remember... easier to prescribe
Please see summary of product information on following page.

LIMBITROL® (IV) Tranquilizer-Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving)
***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs.
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic. Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract
Allergic. Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling
Overdosage: Immediately hospitalize patient suspected of having taken an overdose Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment
Dosage: Individualize according to symptom severity and patient response Reduce to smallest effective dosage when satisfactory response is obtained Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly
Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses
How Supplied: *Double strength (DS) Tablets*, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets*, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100; Prescription Paks of 50.

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Physicians, Attorneys

(Continued from page 279

of a patient who, Dr. Larson said, had refused to follow medical advice. Her malpractice insurance premium was increased by more than 60% due to the suit, she said.

The task force also heard from Belleville neurosurgeon Dr. Michael Murphy, who said his medical group "probably will leave St. Clair County within the next year." He indicated that the group comprises approximately 75% of the neurosurgeons in the area. Dr. Murphy said that, with anticipated premium increases, "I don't think my patients will be able to afford me."

Dr. Donald H. Pearson, a Springfield neurosurgeon, told the task force that the cost of his malpractice insurance was going from about $18,000 a year to $42,000 a year as of October 1. In addition, his carrier was reducing the policy's coverage limits from an upper limit of $1 million to $600,000. Dr. Pearson said physicians "weren't asking that there be no recompense" in cases of true malpractice, but that they "ask only that it be reasonable."

The task force heard from two other physicians. Dr. C. Paula Perkins, a Vandalia radiologist, urged the task force to help "bring the law up to date" and allow countersuits by physicians. Dr. Philip Taxman, a Chicago surgeon, called on insurance companies to "open up their books." Dr. Taxman said he believed the current peer review system "is totally inadequate" and he advised that physicians, "should not be afraid," to discipline their colleagues.

He also called on the medical and legal professions to work together to resolve the malpractice problem.

Also making presentations before the task force were a patient who claimed to have suffered as a result of physician malpractice and two family members of a woman who died after alleged physician neglect.

Daniel J. Mulvanny, general counsel of the Illinois Hospital Association, presented a second IHA statement to the task force with additional information on the cost impact of malpractice on Illinois hospitals. Mulvanny said malpractice premiums comprised 5-7% of average hospital total revenues. He said that a 300% increase was expected in the cost of reinsurance and excess coverage for hospitals insured under the Illinois Provider Trust. As a result, he said, malpractice costs may rise to 14-21% of total revenue. He emphasized that such increases would be a particularly severe burden in light of current cost containment pressures on hospitals.

Mulvanny suggested limiting the statute of limitations for minors filing suits to six years after an incident. He also urged that cases involving custodial care for minors use structured settlements. ◀

FACT

Malpractice reform is critical

FACT

It won't happen without your commitment

FACT

You owe it to your patients and your peers

The evidence is clear
Your profession needs you
Show your commitment where it counts!

Attend the ISMS
Springfield Legislative Rally
For Malpractice Reform

Wednesday, May 22, 1985

On May 22, Illinois physicians and members of the medical family will rally in Springfield at the State Capitol. The purpose is to help legislators understand the seriousness of the malpractice problem and to explain why they should vote "YES" on ISMS legislative proposals. The result will be an impressive demonstration of commitment to controlling the malpractice climate.

Help repeat the victory of May, 1976, when more than 1000 members of the medical family rallied in Springfield in a show of "medical muscle" for malpractice reform. That rally had a tremendous impact in passing similarly critical legislation.

Please show your commitment by returning the coupon below and watch your mail for more information from ISMS.

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Yes, I'll be there when my profession needs me. I'll reserve May 22 on my calendar. Please send me information on how I can register to participate in the Springfield Legislative Rally for Malpractice Reform.

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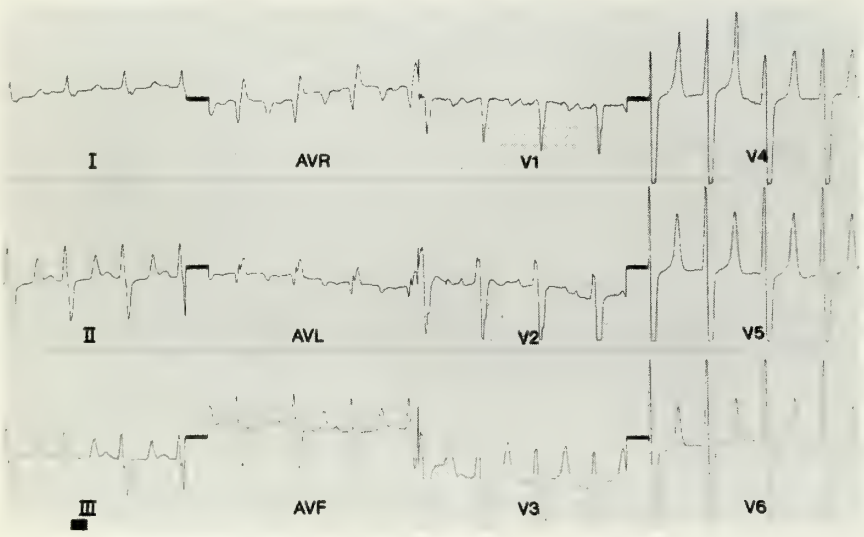
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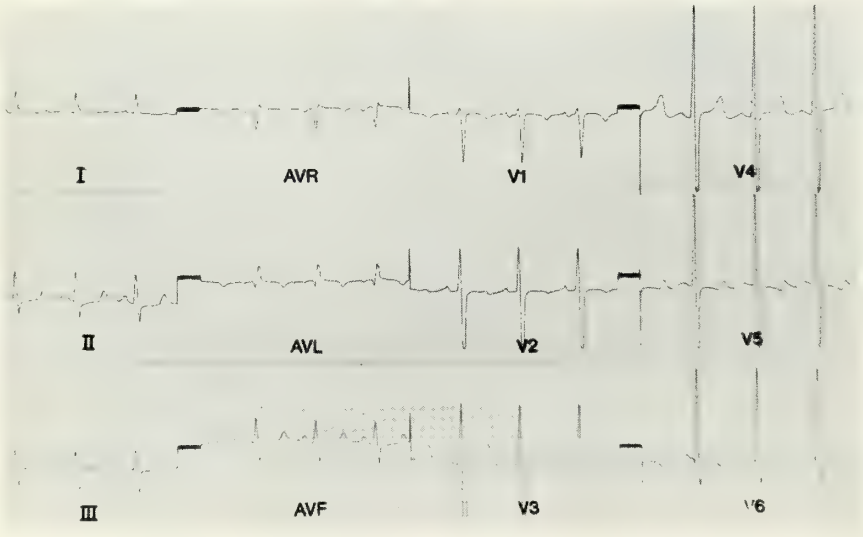
Please return to Illinois State Medical Society, Twenty North Michigan Avenue, Suite 700, Chicago IL 60602; Attention: Springfield Legislative Rally

EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This is a 39 year old patient who was brought to the emergency service because of increasing lethargy over the past few days. He has a 20 year history of insulin dependent diabetes mellitus. He has chronic renal failure secondary to diabetes and has been on regular hemodialysis since 1981. He also has diabetic retinopathy and secondary hyperparathyroidism with metastatic calcifications. This morning he had taken 30 units of NPH insulin but had not eaten all day. There was no history of fever, chills, diarrhea, or vomiting. His physical examination showed a blood pressure of 180/70mmHg and a pulse rate of 88 beats per minute. The cardiac exam consisted of an atrial gallop, normal first and second heart sounds, and a grade 3/6 systolic murmur at the left sternal border. A chest x-ray showed cardiomegaly. These two twelve lead electrocardiograms were taken before and after an intervention. Blood chemistries were drawn and sent to the lab.





Questions:

1. **The first ECG shows:**
 a. Atypical complete left bundle branch block.
 b. An acute high lateral wall myocardial infarction.
 c. Severe right ventricular hypertrophy.
 d. Severe left ventricular hypertrophy.
 e. Findings consistent with hyperkalemia.

2. **Treatment of this patient could include:**
 a. Temporary demand ventricular pacemaker.
 b. Admission to the coronary care unit.
 c. Urgent lowering of his blood pressure.
 d. Cardiac catheterization and coronary angiography.
 e. Hemodialysis.

(Continued on page 298)

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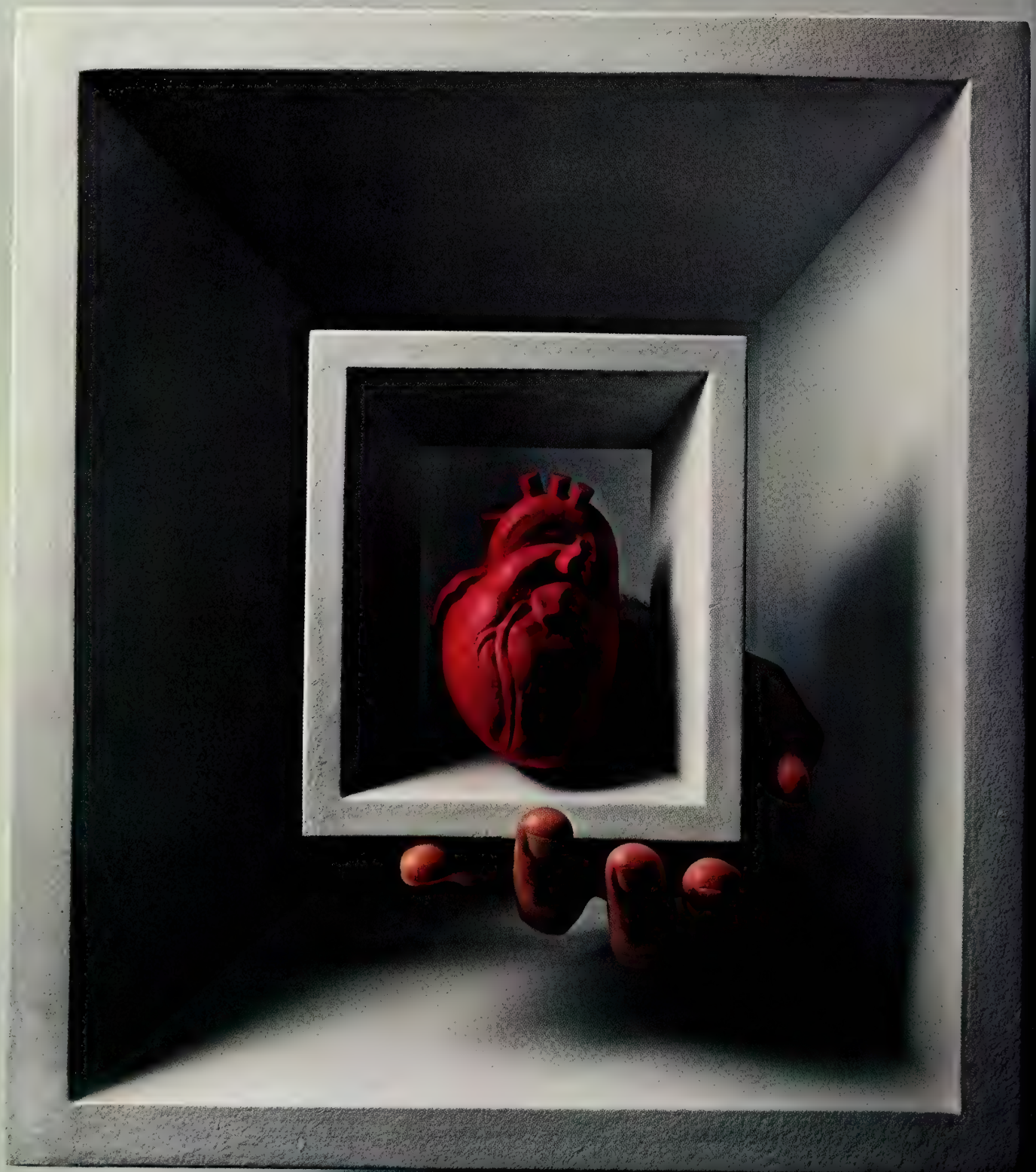
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Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

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DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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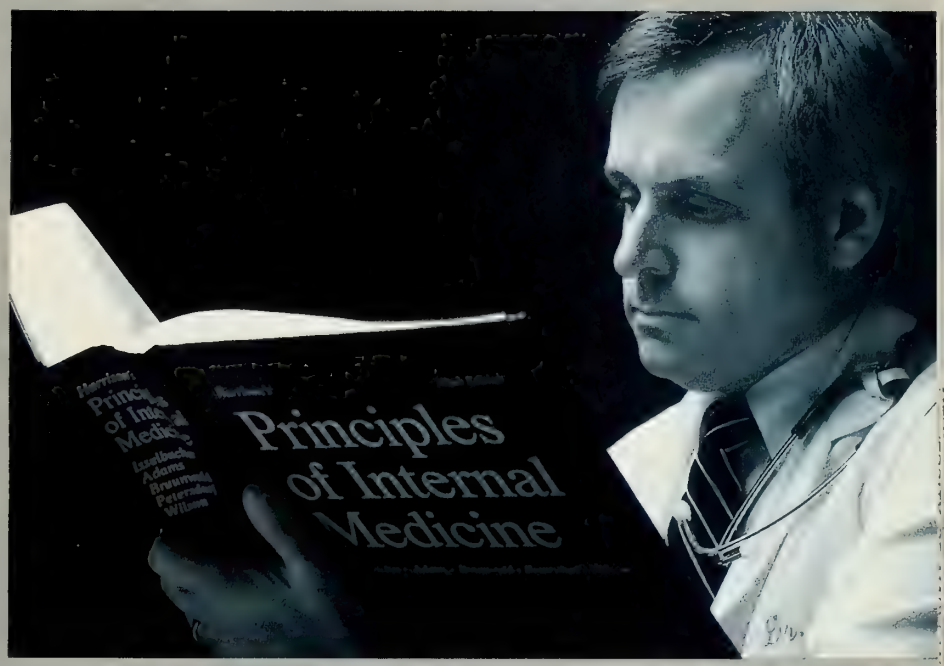
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Obituaries

Braceland, Francis, West Hartford, Connecticut, died February 23, 1985 at the age of 84. Dr. Braceland was a graduate of Jefferson Medical College, Thomas Jefferson University, Philadelphia, Pennsylvania.

****Brooks, Roosevelt,** Chicago, died March 4, 1985 at the age of 83. Dr. Brooks was a 1930 graduate of the University of Illinois College of Medicine, Chicago.

***Figueroa, Liborio,** Chicago, died February 24, 1985 at the age of 89. Dr. Figueroa was a 1924 graduate of the University of Illinois College of Medicine, Chicago.

***Fink, James, R.,** Skokie, died February 22, 1985 at the age of 75. Dr. Fink was a 1938 graduate of Loyola University Stritch School of Medicine, Maywood.

***Frank, Stanwood S.,** Walnut, died March 10, 1985 at the age of 54. Dr. Frank was a 1956 graduate of the University of Illinois College of Medicine, Chicago.

****Hanisch, Ernest J.,** Chicago, died February 22, 1985 at the age of 89. Dr. Hanisch was a 1922 graduate of Loyola University Stritch School of Medicine, Maywood.

***Hockman, Donald E.,** Wheaton, died February 17, 1985 at the age of 70. Dr. Hockman was a 1942 graduate of Northwestern University Medical School, Chicago.

***Joffe, Herman,** Highland Park, died February 27, 1985 at the age of 71. Dr. Joffe was a 1939 graduate of the University of Illinois College of Medicine, Chicago.

***Lea, Robert B.,** Elgin, died February 28, 1985 at the age of 65. Dr. Lea was a 1951 graduate of Northwestern University Medical School, Chicago.

****Mammoser, Lambert F.,** Park Ridge, died February 18, 1985 at the age of 81. Dr. Mammoser was a 1932 graduate of Loyola University Stritch School of Medicine, Maywood.

****Mennite, Nicholas M.,** Dolton, died February 10, 1985 at the age of 75. Dr. Mennite was a 1934 graduate of Loyola University Stritch School of Medicine, Maywood.

****San Filippo, Paul D.,** Chicago, died February 28, 1985 at the age of 76. Dr. San Filippo was a 1932 graduate of the University of Illinois College of Medicine, Chicago.

****Tenney, Roy E.,** Rockford, died February 1, 1985 at the age of 92. Dr. Tenney was a 1919 graduate of McGill University Faculty of Medicine, Montreal, Quebec.

****Weber, Lawrence F.,** Olney, died February 1, 1985 at the age of 83. Dr. Weber was a 1929 graduate of Washington University School of Medicine, St. Louis.

****Weinstein, Morris L.,** Beverly Hills, California, died February 11, 1985 at the age of 91. Dr. Weinstein was a 1913 graduate of Chicago College of Medicine and Surgery.

*Indicates ISMS member
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A Little Concern About Me and My Folks

Dear Editor:

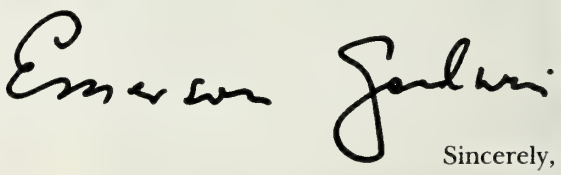
Seasons are recognized in many ways. At the Apollo, noting those present at the ten o'clock coffee roundtable provides an accurate seasonal assessment. There are the hard core regulars—listeners, conversationalists, and philosophers. To that group the seasonal indicators are added. Rapher and Willard have joined us now, a sure indication of winter—a nonworking time for row crop farmers. Nonfarming farmers could be a more appropriate term, because Raph and Willard are in a constant frenzy of activity checking the papers, talking to the elevator folks, checking the latest grain and future quotes with each other and on and on. For almost a month now any topic other than "the plight of the farmer" gets shoved to the conversational back pages. We are all so aware of the farmer's declining profits, burdensome interest rates, and unfair government farm policy that we are no longer listening. We all look forward to a mercifully early and mild spring so our single item colleagues can get out of the Apollo and back into the field.

We had an opportunity to briefly examine our situation when Raph and Willard were detained at the elevator hoping for a new and more favorable quote. We all readily agreed that this farm dominated conversation of the past few weeks was tedious, even boring, because of its singleness. "Everyone, even an old codger," stated Asa, "requires some variety! Worse, it's hard to keep up a degree of interest and respect when all they talk about is what's good for farmers."

"Yep," added Chick, "at this point I don't much care what's good for them any longer. Maybe if they told us which corn product is better for us or how we could wisely or inexpensively use their farm products. . . ."

Asa pondered a moment and seeing the gloom and doom pair heading in the door capped off the brief discussion with, "A self-interest conversation needs to be tempered with some of what's good for the rest of us, else the self-interest message is ignored."

We all picked up our checks and headed for the door. A short while later with this vignette burning bright in my memory, I picked up and read a batch of my misdirected medical mail. The parallel was startling. Aware that our continuing relationship would be at risk, I must nevertheless chide you of the medical profession in a manner like, but more direct than, Asa's admonition to Raph and Willard. A great deal of self-interest and very little public interest is what I read and hear from your professional organization. The primary purpose of your professional organization—ISMS—is and should be the support, protection and improvement of your profession. However, to preserve your public image, (and that's important to the profession as well) some activity must take place for the public interest and good. I may have missed it, but I see nor hear none of that. If Asa were asked, he would likely say, "A large dose of self-interest can be tolerable, and I'll accept that and even help it if a little concern is shown about me and my folks!" ◂



Sincerely,

Emerson Goodwin

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TALWIN® Nx...BUILT-IN PROTECTION AGAINST MISUSE BY INJECTION

Major Analgesic Reformulated

Now contains naloxone, a potent narcotic antagonist

Extra security added to proven efficacy and safety

No longer do doctors have to deny patients the benefit of an effective oral analgesic for fear of its misuse by injection.

Winthrop-Breon Laboratories has met a nagging problem by reformulating TALWIN® 50 (pentazocine HCl tablets) with the addition of naloxone, equivalent to 0.5 mg base. The reformulated product is called TALWIN® Nx.

The original formulation had been subject to a form of misuse among street abusers known as "T's and Blues." TALWIN 50 and PBZ,* an antihistamine, would be ground up together, put into solution, and injected intravenously. The combination produced a heroin-like high. Because naloxone is a narcotic antagonist when injected intravenously, it acts to nullify any high a "T's and Blues" addict might expect from the pentazocine in a combination of TALWIN Nx and PBZ. When taken as directed orally, the naloxone component of TALWIN Nx is inactive. Thus, TALWIN Nx continues to be a safe, effective, oral analgesic for the relief of moderate to severe pain, now providing added security against misuse.

*Registered trademark of Ciba-Geigy Corp for tripelennamine.



Talwin® Nx*

IV Each tablet contains pentazocine HCl, USP, equivalent to 50 mg base and naloxone HCl, USP, equivalent to 0.5 mg base.

The reformulation of Talwin 50 to Talwin Nx involved the addition of 0.5 mg naloxone to help prevent misuse by injection.

*In Illinois, TALWIN Nx is a Schedule II controlled substance and requires a triplicate prescription.

Please see following page for Brief Summary.

Winthrop-Breon

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Talwin® Nx® IV

Each tablet contains pentazocine HCl, USP, equivalent to 50 mg base and naloxone HCl, USP, equivalent to 0.5 mg base.

Analgesic for Oral Use Only

Contraindications: Hypersensitivity to either pentazocine or naloxone.

TALWIN® Nx is intended for oral use only. Severe, potentially lethal, reactions may result from misuse of TALWIN® Nx by injection either alone or in combination with other substances. (See **Drug Abuse and Dependence** section.)

Warnings: *Drug Dependence.* Can cause physical and psychological dependence. (See **Drug Abuse and Dependence**.) *Head Injury and Increased Intracranial Pressure.* As with other potent analgesics, respiratory depressant effects of the drug may elevate cerebrospinal fluid pressure due to CO_2 retention; these effects may be markedly exaggerated in the presence of head injury, other intracranial lesions, or a preexisting increase in intracranial pressure. Can obscure the clinical course of patients with head injuries; in such patients, use with extreme caution and only if deemed essential. *Usage with Alcohol.* Due to potential for increased CNS depressant effects, alcohol should be used with caution. *Patients Receiving Narcotics.* Pentazocine is a mild narcotic antagonist. Withdrawal symptoms have occurred in patients previously given narcotics, including methadone. *Certain Respiratory Conditions.* Should be administered with caution in respiratory depression from any cause, severely limited respiratory reserve, severe bronchial asthma and other obstructive respiratory conditions, or cyanosis.

Precautions: *CNS Effect.* Use cautiously in patients prone to seizures; seizures have occurred though no cause and effect relationship has been established. Therapeutic doses have in rare instances, resulted in hallucinations (usually visual), disorientation, and confusion, which cleared spontaneously within a period of hours. Such patients should be very closely observed and vital signs checked; if the drug is reinstituted, it should be done with caution since the acute CNS manifestations may recur. *Impaired Renal or Hepatic Function.* Decreased metabolism of pentazocine in extensive liver disease may predispose to accentuation of side effects; it should be administered with caution in renal or hepatic impairment. In long-term use, precautions should be taken to avoid increases in dose by the patient. *Biliary Surgery.* Some evidence suggests that unlike other narcotics pentazocine causes little or no elevation in biliary tract pressures; the clinical significance of these findings is not yet known. *Information for Patients.* Since sedation, dizziness, and occasional euphoria have been noted, ambulatory patients should be warned not to operate machinery, drive cars, or unnecessarily expose themselves to hazards. May cause physical and psychological dependence taken alone and may have additive CNS depressant properties in combination with alcohol or other CNS depressants. *Myocardial Infarction.* Use with caution in patients with myocardial infarction who have nausea or vomiting. *Drug Interactions. Usage with Alcohol.* See **Warnings.** *Carcinogenesis, Mutagenesis, Impairment of Fertility.* No long-term studies in animals to test for carcinogenesis have been performed. *Pregnancy Category C.* Should be given to pregnant women only if clearly needed. *Labor and Delivery.* Use with caution in women delivering premature infants. Effect on mother and fetus, duration of labor or delivery, need for forceps delivery or other intervention or resuscitation of newborn, or later growth, development, and functional maturation of the child is unknown. *Nursing Mothers.* Caution should be exercised when administered to a nursing woman. *Pediatric Use.* Safety and effectiveness in children below the age of 12 years have not been established.

Adverse Reactions: *Cardiovascular:* Hypotension, tachycardia, syncope. *Respiratory:* Rarely, respiratory depression. *CNS. Acute CNS Manifestations:* In rare instances, hallucinations (usually visual), disorientation, and confusion which have cleared spontaneously within a period of hours, may recur if drug is reinstituted. *Other CNS Effects:* Dizziness, lightheadedness, sedation, euphoria, disturbed dreams, hallucinations, irritability, excitement, tinnitus, tremor. *Gastrointestinal:* Nausea, vomiting, constipation, diarrhea, anorexia, rarely abdominal distress. *Allergic:* Edema of the face; dermatitis, including pruritus; flushed skin, including plethora. *Ophthalmic:* Visual blurring and focusing difficulty. *Hematologic.* Depression of white blood cells (especially granulocytes), which is usually reversible, moderate transient eosinophilia. *Other:* Headache, chills, insomnia, weakness, urinary retention.

Drug Abuse and Dependence: *Controlled Substance.* TALWIN Nx is a Schedule IV controlled substance.

Dependence and withdrawal symptoms have been reported with orally administered pentazocine. Patients with a history of drug dependence should be under close supervision. Possible abstinence syndromes in newborns after prolonged use of pentazocine during pregnancy have been reported. In prescribing for chronic use, the physician should take precautions to avoid increases in dose by the patient. Tolerance to the analgesic effect is rarely reported; there is no long-term experience with oral use of TALWIN Nx.

The amount of naloxone present (0.5 mg per tablet) has no action when taken orally and will not interfere with the pharmacologic action of pentazocine; however, this amount of naloxone given by injection has profound antagonistic action to narcotic analgesics. TALWIN Nx has a lower potential for parenteral misuse than the previous oral pentazocine formulation, but is still subject to patient misuse and abuse by the oral route.

Severe, even lethal, consequences may result from misuse of tablets by injection either alone or in combination with other substances, such as pulmonary emboli, vascular occlusion, ulceration and abscesses, and withdrawal symptoms in narcotic dependent individuals.

Overdosage: *Treatment:* Oxygen, intravenous fluids, vasopressors, and other supportive measures should be employed as indicated. Assisted or controlled ventilation should also be considered. For respiratory depression, parenteral naloxone is a specific and effective antagonist.

Please consult full product information before prescribing.

Winthrop-Breon

WIN 4-41415AR2

Winthrop-Breon Laboratories
Division of Sterling Drug Inc.
New York, NY 10016

EKG

(Continued from page 284)

Answers: 1. E 2. E

Despite this patient's relatively mild complaints, his condition required urgent treatment. The first ECG shows sinus rhythm with a normal PR interval. The QRS is widened and resembles a QRS conduction defect. The T waves are tall and peaked and not consistent with a bundle branch block. This is strongly suggestive of hyperkalemia. The ECG manifestations of hyperkalemia are peaking of the T wave with an increased T wave amplitude, widening of the QRS, and later loss of atrial activity. Near the end the ECG may show a sine wave pattern before cardiac arrest occurs. Tall peaked T waves may be an early ECG sign of hyperkalemia but they may not be equally dramatic in all leads. They are prominent in leads V_3 to V_6 but less so in leads I, V_1 and V_2. Treatment with 10-20ml of 10% calcium chloride will offset the effects of hyperkalemia. If acidosis is present with hyperkalemia, one or two ampules of sodium bicarbonate (44-88mEq) can be given intravenously. These medications may have to be given before any lab values are available by following changes on the ECG. Lab values in our patient showed a potassium of 7.1mEq/l, bicarbonate 14mEq/l, calcium 8.4mg/dl, pH 7.22 and glucose 25mg/dl.

In addition to the above medications, three ampules of 50% dextrose and water were given. Glucose and insulin can be used to drive the potassium back into body cells. However, the problem is to lower body stores of potassium. This can be accomplished most effectively by hemodialysis. Ion exchange resins are also useful in some patients.

The second ECG was taken when the patient's potassium was in the normal range and now shows left ventricular hypertrophy with the strain pattern. After twenty to thirty years of insulin dependent diabetes, as many as half the patients will develop renal failure due to lesions in the microvasculature of the renal glomerulus. Three-fourths of these long-term diabetic patients will have significant abnormalities in the retina caused by microangiopathy. Secondary hyperparathyroidism is a frequent complication of chronic renal failure causing calcification in the intima and media of arteries, sinoatrial and atrioventricular nodes, valve cusps, and the annuli of the valves. The arterial involvement can cause ischemia and even gangrene. ◀

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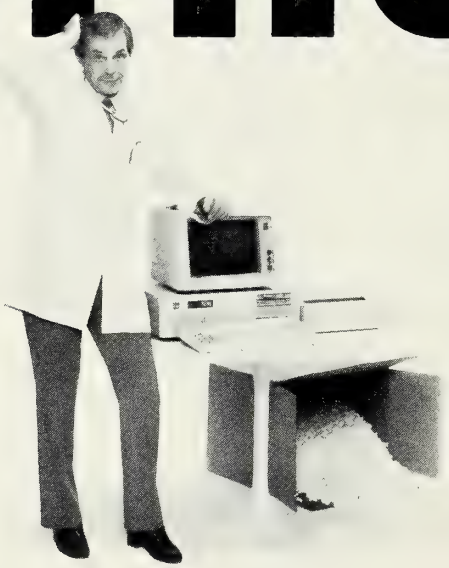
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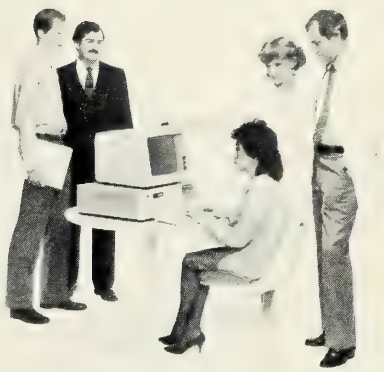
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The Hidden Cost of Health Care

Malpractice

Physicians spend so much time talking to each other about how malpractice premiums are rising, that they often forget who's really paying the bill—the public. Members of the public may not realize it because the costs are usually hidden.

Physicians should talk to their patients and other lay persons about malpractice and how the public is paying for a malpractice system out of control. Patients and other non-physicians should be encouraged to contact their own state representatives and senators. Legislators are anxious to hear thoughts on this issue from people other than physicians and trial attorneys.

The malpractice problem has a very real effect on the cost of health care in Illinois. More than $200 million in annual malpractice insurance premiums is passed on to patients by Illinois physicians and hospitals. But insurance premiums are only part of the story. There are many other costs associated with malpractice—costs that are hidden and unnecessary. Among them are:

The cost of too many frivolous lawsuits for alleged medical malpractice.

The cost of increasingly high settlements and jury awards in medical malpractice cases.

The cost of unnecessary tests, longer hospital stays and physicians calling on other physicians for consultation and referral—done only to create a record that will withstand the threat of a malpractice suit.

The cost of Illinois physicians leaving the state or quitting the practice of medicine altogether.

The cost of people not being able to get high risk care because physicians are afraid to engage in high risk practices.

The cost of patients truly injured by malpractice being forced to wait for court hearings because court dockets are crowded with frivolous suits.

Employers are looking for ways to provide their employees with the best health care at the most reasonable expense. But many employers have had to increase the amount an employee pays for such coverage, and others are eliminating coverage for spouses, children or certain types of care. And every dollar spent for health care benefits is one less dollar available for the employee's paycheck.

Problem Accelerating

Unfortunately, the situation keeps getting worse. Claims involving Illinois' largest malpractice insurance carrier, the Illinois State Medical Inter-Insurance Exchange, increased 163% from 1977 to 1984.

Furthermore:

- Some 80% of the Exchange's suits are resolved with no fault found with the physician's care.
- The Exchange has paid more than $8.5 million to defend physicians in these non-meritorious suits—costs which are ultimately passed on to patients.
- Defensive medicine—tests, extra hospital stays and referrals to other physicians—costs more than $725 million annually.
- Malpractice-related costs are the fastest growing component of health care costs.

The Illinois State Medical Society is proposing a package of legislative reforms. If adopted, these new laws would provide for:

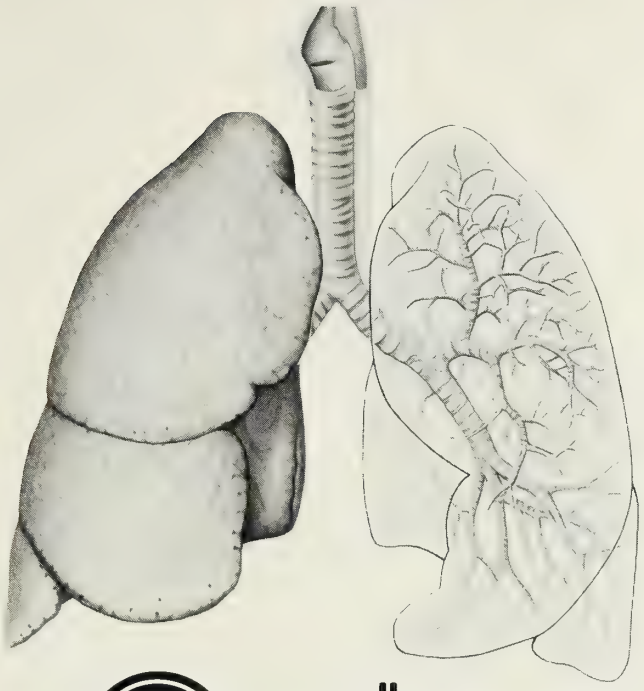
- Just and swift compensation for any patient truly harmed by health care provider negligence;
- Better-informed juries who can make reasonable decisions;
- Curbs on the abuse of the legal system.

Patients concerned about rising malpractice costs can help their physicians bring about a solution to the problem. All patients should write or call their state senators and representatives to emphasize the importance of the malpractice problem and encourage them to adopt reform legislation.

Representatives and Senators may be written to at the Senate Post Office or House Post Office, State Capitol, Springfield, IL 62706. Their offices can be reached by phone through the main Capitol switchboard, (217) 782-2000.

Patients who are unaware of who their legislators are can ask their company public affairs department or call local election officials. Or they can contact the Illinois State Medical Society for assistance at Twenty North Michigan Avenue, Chicago, IL 60602; (800-782-ISMS) or (312-782-1654). ◂

Consider the causative organisms...



Ceclor®
cefaclor

250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) **(ampicillin-resistant)**

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets, but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — *Pregnancy Category B* — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor® (cefaclor, Lilly) have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions. Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Their Purpose and Relationship to the Medical Profession

Rape Crisis Services

By Donna J. Lederle, M.A., Janice DiGirolamo, and Polly Poskins, M.S./Springfield

At the 1983 Annual Meeting, the ISMS House of Delegates adopted Resolution 25(A-83), which directed that the Society (1) support the rape victim's option to have continuous presence of a rape victim counselor during medical care if available and desired; (2) inform the membership of the function and efficacy of rape victim services and (3) encourage that rape crisis centers continue to work with local police officials in helping rape victims. This month we feature articles developed at the request of the ISMS Council on Medical Services to fulfill the intent of that resolution.

Editor's Note: While the female pronoun is used throughout this article, it should be understood that most of the information is equally pertinent to victims of both sexes.

Knowledge and use of rape crisis centers results in more comprehensive care for the victim as she is provided medical treatment. Member programs belonging to the Illinois Coalition of Women Against Sexual Assault have trained staff and volunteers who assist victims if they seek medical care after sexual assault. The advocate who accompanies a victim to an emergency room, clinic or physician's office is prepared to facilitate the reduction of problems and conflicts surrounding the victim. A victim's medical treatment experience and follow-up care can be a positive, contributing part of the recovery whenever medical personnel and rape crisis centers work together on a victim's behalf.

When working with a sexual assault victim, a medical practitioner is placed in the position of treating physical wounds, soothing emotional trauma and gathering evidence. While this is a demanding process, it is critical to the victim's physical well-being and emotional recovery.

The victim's initial contact with medical personnel after the sexual assault has a lasting effect. For that important reason, this article will focus on providing information that will assist physicians and medical personnel in working with sexual assault victims in a way that will aid their emotional recovery.

Myths and their Detrimental Effect on Victims

Sexual assault has come to be a common experience for members of our society. Estimates are that one in four girls and one in ten boys will be sexually abused by the age of 18;[1] that one in six women will be raped in her lifetime;[2] that at least one-half of the sex offenders themselves have been sexually abused.[3] The statistics are revealing: sexual assault affects most of us directly or indirectly as victims, loved ones of victims, or service providers to victims.

Substantiating data and actual cases, however, have not eradicated the myths that surround sexual assault. Two of the major and most detrimental myths are that sexual assault is a sexually motivated crime and that victims are usually unknown to the offender. Maintaining these myths is harmful for obvious reasons; they seriously complicate a victim's trauma.

Sexual assault, whether rape or incest, is a pseudosexual act—a pattern of sexual behavior that is concerned much more with status, hostility, control and dominance than with sensual pleasure or sexual satisfaction. It is sexual behavior in the service of non-sexual needs.[4]

Many victims, helpers, significant others, law enforcement officials—the public generally—are still confused about whether sexual assault is a sexually motivated act. The belief that sexual assault is sexually motivated places the blame on the victim. This assumes that the attacker is the aroused and is being acted upon by the victim as the arouser.

Whether the victim has this attitude and is blaming herself, or

someone else has this erroneous thought and is blaming the victim, this attitude makes the healing process longer and more difficult. A helper must make the assumption that all victims are truthful, and sincerely believe that victims are not accomplices in their sexual assaults.

It is the experience of rape victim advocates that those in helping professions have most difficulty in believing the victim when working with prostitutes, street kids, males, long-term incest victims, victims who do not have extreme signs of physical or emotional distress and victims who were sexually assaulted by a husband or an acquaintance.

Sexual assault victims are victimized approximately 80% of the time by people they know.[5] This applies to children and adults. Believing that most victims are not known by their assailant also perpetuates victim blaming. "Why would someone you know harm you unless you did something to cause it?" is a far too common refrain.

Helpers need to examine their own attitudes when working with sexual assault victims. Attitudes may be apparent despite efforts to maintain neutral behavior. The victim may perceive these negative attitudes; reinforcing self-blame and making recovery more difficult. In the process of recovery, it's important that the victim does not blame herself.

The victim needs compassion and empathy. A helper's ability to give it will make a difference in the victim's healing experience. This is one of the reasons medical personnel choose to involve rape victim advocates in the victim's hospital experience. The total focus of the victim advocate can be on the victim's emotional status.

Rape Trauma Syndrome

When the victim who has been assaulted comes to the hospital, she will express symptoms common to sexual assault victims which Ann Burgess and Lynda Holmstrom have defined as *rape trauma syndrome*.[6] The sexual assault victim experiences a crisis reaction because the experience is beyond the victim's ability to cope. Burgess and Holmstrom describe two phases of rape trauma syndrome: the acute phase of disorganization and a long-term process of reorganization. (The reorganization phase will not be discussed in this article.) The acute phase occurs immediately after the assault when the victim's life is totally disrupted and lasts from a few days to a few weeks.[6]

At the initial interview the victim may show a wide range of emotions; the main styles of emotions are expressed and controlled. When displaying emotions in a controlled style, the victim's feelings are masked and the person appears to be calm or composed. In the expressed style of release, the victim demonstrates fear, anger, anxiety and uncertainty. A victim's outward behavior may not reflect the degree or nature of the emotional trauma experienced.[6]

The chief emotional reaction to the sexual assault is fear. Shame, guilt, humiliation, anger, embarrassment and self-blame are feelings expressed in conjunction with the overriding emotion of fear—fear of death, mutilation, retaliation and physical injury. Rape trauma syndrome symptoms are an acute stress reaction to the threat of being killed.

During the first few weeks, when symptoms are acute, the victim may be irritated with other people. She may feel that her life is out of control. She will continually try to block out thoughts of the assault, but they will continue to be present.[6]

During this phase, the victim may describe physical soreness, sleep and eating disturbances. The soreness may or may not be specific to that area of the body where the attack was focused. Sleeping disturbances can include inability to fall asleep, waking up during the night, nightmares and screaming out during sleep. Eating disturbances include nausea, stomach pains, and loss of appetite. These symptoms may be emotional reactions or a physical reaction to anti-pregnancy medication.[6]

The kind of treatment a rape victim receives will affect her recovery. The hospital experience can aid the victim or contribute to further distress.[7] The quality of treatment a victim receives is in direct relation to the protocol of the particular hospital.

Some of the key results of a good protocol would be: (1) a victim received immediate medical attention, privacy and emotional support; (2) standardized quality collection of evidence; (3) a physical examination; and (4) the offering of follow-up care.[6]

What the Victim Needs From the Physician and the Facilities

Privacy is important to the sexual assault victim. The victim should be taken to a quiet room where the initial interview can be conducted without interruption. The victim should be able to concentrate and feel comfortable in displaying emotion.

The sexual assault victim needs support. If a rape victim advocate is not present, the victim should be asked if she would like to have someone called to come and be present.

Because the victim has just been in the situation of having someone else decide whether she lives or dies, it is imperative that the person begin to re-establish personal will. The victim should be allowed as much control as possible over what happens to her after the assault.[6,7]

The victim needs to know, step by step, what will be done and for what purpose. Victims need to understand how they'll benefit from what is being done.[6,7]

The physician should begin by expressing regret that the patient has been assaulted, by reassuring the victim of her safety.[7] The victim should not be left alone if at all possible.[6]

Before asking questions for a history of the event, the physician should discuss the process with the victim and ask permission to proceed. By treating the patient with respect, compassion and honesty, the victim will be encouraged to respond positively.[7] The physician's ability to remain calm and supportive no matter what the emotions of the victim will be calming to the victim.[6]

Going slowly in the physical examination is important, as rushing a victim will feel like forcefulness to her—A reminder of the

sexual assault.[7] It should not be assumed that the victim has had a pelvic examination previous to this event. Many women have never had a pelvic exam.[6]

While the law requires that the hospital make a police report, it does not require that a victim talk to the police or make a report. A victim should be asked whether she wishes to talk to a police officer and if not, that wish should be respected.

If the hospital is covered by the Rape Victim Emergency Treatment Act, the victim should be told not to be concerned about medical hospital charges. If information is needed regarding the victim's insurance or hospital billing, try to keep this very brief. It is preferable that it be done at another time. The victim should be given something in writing to refer to later.

In addition to fear, pregnancy and venereal disease are the two other overriding concerns of many sexual assault victims. Statistics show that only 3-5% of women who are raped become pregnant as a result. There is an estimated 96% chance that no pregnancy will occur from a single act of unprotected intercourse. In deciding whether to prevent a possible pregnancy and in what way, the victim may take into consideration where she is in her menstrual cycle. If she is mid-point, the chances of pregnancy are high. If she was menstruating at the time of the assault, pregnancy is less likely.[6]

Because many of the drugs available to prevent pregnancy have such damaging side effects, the victim should be made aware of the level of pregnancy risk and offered non-drug alternatives to preventing pregnancy.

The alternatives available are: (1) waiting to determine whether the victim begins her next period or until such time as the results of pregnancy test are known; (2) menstrual extraction, if the next period is late; (3) diethylstilbestral (DES) provided the victim presented herself at the hospital within 24 hours after the assault; (4) post-coital IUD, inserted within five days of suspected assault and retained for at least seven days. There are two kinds of intrauterine devices which can be inserted—copper 7 and progesterone T—insertion up to five days after a rape will prevent pregnancy.[6]

Where venereal disease is concerned, the victim should be told that she has been tested for venereal disease in order to determine whether or not it was present prior to the assault. The patient should be advised of the dangers of venereal disease and how it is transmitted.

It is helpful to give the victim information in writing about the treatment just received for pregnancy and venereal disease.

As a side note, physicians should test for gonorrhea in young children who have been sexually abused. Physicians need to be alert to gonorrhea in young children signalling sexual abuse; there is little evidence to support nonsexual transmission of venereal disease in any age group.[8]

Rape Crisis Center Functions

Rape crisis centers began forming in Illinois in the early 70's to establish rape hotlines, to provide emotional support to sexual assault victims and to assist them in interacting with medical and law enforcement personnel, states attorneys and the courts. While centers now tend to have full-time staff, volunteers still form the basis of the staffed centers' hotline and advocate services, and in some areas centers are still volunteer operated.

Rape crisis centers' programs vary from place to place, but generally they provide these services: a 24-hour hotline and advocate services, public education and prevention programs, counseling, training for those providing direct services to sexual assault victims, (law enforcement and medical personnel, state's attorneys, counselors) and volunteer training and development.

Victims usually access a rape crisis center through the center's hotline. When a sexual assault victim contacts a rape crisis center for help, advocates are dispatched to meet the victim and assist her in whatever way she chooses.

At the hospital, the advocates seek to ensure privacy for the victim, to restore some sense of personal control and to facilitate the reduction of problems and conflicts surrounding the victim.

Rape crisis centers work on a regular basis in the local law enforcement agencies, and the states attorney's office and local hospitals. Those centers with child programs also work with youth service bureaus and the Illinois Department of Children and Family Services. Because of these cooperative relationships, rape crisis centers can easily intercede for the victim as needed to interact with the various public agencies.

Because rape crisis centers function around the clock, the advocate can further assist the victim in finding a safe place to stay, talking to relatives, mates, friends and parents, and providing follow-up counseling for the victim and her family or friends.

Rape crisis centers will only provide their services to those victims who choose to accept their assistance. In Illinois, rape crisis services received through centers funded by the Illinois Coalition of Women Against Sexual Assault are free.

Rape crisis centers can provide medical personnel with assistance in providing emotional support to the victim, by providing staff training and by coordinating the various interactions of personal and public interests with the victim.

The role of the rape crisis center in a community is to assist victims directly through support, advocacy and counseling, to provide education on and prevention of sexual assault to the community and to assist service providers in upgrading services for sexual assault victims. Law enforcement personnel, state's attorneys, the courts, and hospitals can attest to the value of rape victim advocates in making their work easier. Local police rely on rape crisis centers to help those who choose to report get through the report. Medical personnel can use rape crisis centers to ensure that victims get to appointments. States attorneys utilize the assistance of rape victim advocates who provide emotional support to help the victim and her family through the court experience.

Rape crisis centers work with hospital personnel as well as medi-

cal personnel in private practice. They do not take the place of a doctor or compete with the medical establishment, but should be seen as complementing medical treatment of the victim similar to a good friend looking out for the victim's interests and well-being.

In those areas where no rape crisis center exists, a number of alternatives may be considered: (1) arranging to have the closest rape crisis center train your staff in the myths and dynamics of sexual assault; (2) establish an internal counseling service; (3) organize a community rape crisis advocates' organization by publicizing the need and by assisting them in gaining funding; and (4) establishing a sexual assault victim protocol for your facility which is sensitive to the victim's need for emotional support, in conjunction with physical treatment. ◀

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Rape Victim Services

By Donna J. Lederle, M.A., Janice DiGirolamo and Polly Poskins, M.S./Springfield

The Rape Victims Emergency Treatment Act requires that hospitals render emergency hospital service to rape victims who request treatment and provides for reimbursement of costs by the state in certain cases.

In 1976, the Rape Victims Emergency Treatment Act became law. Its purpose is to require hospitals to give emergency hospital service to sexual assault victims who request treatment, regardless of ability to pay. The act provides for reimbursement by the state to the hospital when the client has neither IDPA coverage nor insurance; it also mandates minimum requirements for hospitals providing emergency service to sexual assault victims. These requirements include:

(1) Providing for appropriate medical examinations and laboratory tests necessary to ensure the health, safety, and well-being of an alleged sexual assault victim. This includes, but is not limited to, a general physical exam, serological test for syphillis, stains and cultures for gonorrhea from vagina-penis, anus, and oropharynx.

(2) Providing for appropriate evidence collection which may be used in a criminal proceeding against a person accused of sexual assault. This shall include all components contained in the Vitullo Evidence Collection Kit for Sexual Assault Examination and shall be collected according to the prescribed manner stated in the kit instructions.

(3) Providing that the records of results of these examinations and tests be kept by the hospital and made available to law enforcement officials upon request of the alleged rape victim. The medical record must include, but is not limited to, information regarding whether or not the client changed clothes, bathed, douched, urinated, defecated, had an emesis, performed oral hygiene, or smoked. The record must also show the presence or absence of trauma which may be used in a criminal proceeding. Because such terms as "criminal sexual assault" or "criminal sexual abuse," reflect legal decisions, the medical record must state "alleged sexual assault," or "patient states." It cannot reflect conclusions regarding whether or not a crime occurred.

The medical history shall include brief general information concerning possible injury, drug allergies, and, for female patients, a detailed gynecological history — menstrual history, whether patient knows or believes she is pregnant, prior gynecological surgery, contraception history, and condition of hymen.

(4) Providing medication as deemed appropriate by the attending physician.

(5) Providing the client both oral and written information, which the client shall receive, concerning the possibility of infection and sexually transmitted diseases, a description of the more common signs and symptoms and complications of these diseases, and the need for a second blood test six weeks later.

(6) Providing the client both oral and written information, which the client shall receive, concerning pregnancy resulting from the assault as

determined by physical findings and fertility status, available types of prevention of unwanted pregnancy, and side effects, significant contraindications, complications and limitations of the method employed. If the hospital does not provide such counseling because of religious preferences, providing a list of rape crisis centers in the area will suffice. However, the patient must be advised to contact such agencies within 24 hours of the incident.

(7) Providing the client both oral and written information, which the client shall receive, on accepted medical procedures, medication, and significant contraindications of such medications.

(8) Providing appropriate counseling, by trained personnel, which provides:
 a) emotional support;
 b) confidentiality;
 c) explanations of treatment and related questioning to insure that the patient understands the procedures necessary for his/her health, safety, and welfare;
 d) distribution of the Illinois Department of Public Health sexual assault brochure which contains information concerning criminal justice agencies and questioning of same; Crime Victims Compensation Act; reporting the crime to police; patient consent procedures and Rape Shield Law, Illinois Revised statutes, Chapter 38, Paragraph 115-7;
 e) referrals, which may include counseling centers, consultation with social and law enforcement agencies and volunteer agencies.

(9) Assuring that law enforcement personnel remain outside the examination room during the physical examination.

The Rape Victims Emergency Treatment Act requires that every hospital submit to the Illinois Department of Public Health a plan to provide hospital emergency services to alleged sexual assault victims. Approval of this plan by the Illinois Department of Public Health is necessary prior to its use by the facility. This approval is also necessary prior to the facility requesting reimbursement from the Department.

Reimbursement for this program is paid directly to the hospital. The hospital may include charges for physician, laboratory, Xray, pharmacy, physician consultation, ambulance services, and other charges if they are for hospital emergency care directly related to the sexual assault and were incurred within 72 hours of the alleged assault. The Department will also reimburse the laboratory charges for the six weeks' follow-up blood test. The hospital must indicate that the patient is not eligible for public aid and is not covered for these services by an insurance policy. Physician fees should be those considered usual and customary in the community.

The Illinois Department of Public Health will not reimburse patients, physicians, ambulance providers, or other parties directly. Inpatient care is not covered.

The Illinois Crime Victims Compensation Act administered by the attorney general covers the inpatient care expenses. Other provisions of the Rape Victims Emergency Treatment Act include:

- Providing assistance in the development and operation of programs which provide emergency services to alleged rape victims and, where necessary, grants to hospitals for this purpose.
- Provision that any hospital violating any provisions of the act shall be guilty of a petty offense for each violation, and any fine imposed shall be paid into the corporate funds of the city, incorporated town or village in which the hospital is located, or of the county, in case the hospital is outside the limits of the incorporated municipality.
- Stipulation that nothing in the act is to be construed to require that a hospital provide any services which relate to an abortion.

The legislation is a part of the Illinois Hospital Licensing Act. ◂

Biographical Information

Complete biographical information about the authors is published on page 308.

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1. A complete bibliography for "Rape Victim Services," may be obtained by writing the Illinois Medical Journal, Twenty North Michigan Avenue, Suite 700, Chicago IL 60602.

As a Complication of Acute Asthmatic Attack

Pneumopericardium

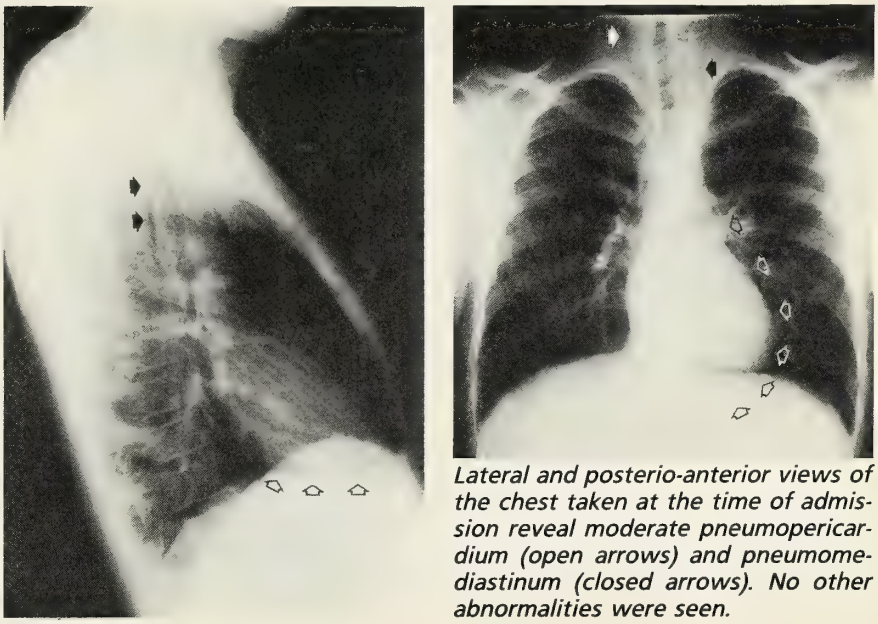
By Nicholas V. Augelli, M.D. and Rif S. El-Mallakh, M.D./Royal Oak, Michigan and Farmington, Connecticut

Pneumopericardium is a very rare complication of asthma and has been reported only once previously in the English literature.[1] We here report the second case.

A 13-year-old Caucasian male with a six year history of asthma presented with labored breathing, shortness of breath, wheezing, chest tightness, and sternal chest pain of ten hours' duration. The pain was sharp and recurrent, and radiated to both shoulders and lateral chest walls. The patient also complained of diaphragmatic and abdominal pain. Physical examination revealed the patient to be tachypnic (28/minute) and tachycardic (120/minute), with distant heart sounds and a blood pressure of 140/60mmHg. The patient was most comfortable when breathing while sitting up and leaning forward with his shoulders drooped down and forward. Moderate subcostal retraction was present. Wheezing was mainly expiratory and present bilaterally. The expiratory to inspiratory ratio was increased. Hamman's sign was positive. A roentgenographic examination of the chest (Figure 1) revealed pneumomediastinum and pneumopericardium. Neither pneumothorax nor pulmonary infiltrates were seen. After admission bronchodilators were administered both orally and by inhalation and the patient was hydrated. No specific treatment was instituted for either the pneumomediastinum or the pneumopericardium. The course of the hospitalization was uneventful, and the patient was discharged three days after admission on oral bronchodilators. At the time of discharge there was some residual pneumopericardium and pneumomediastinum. At one month follow-up there was total resolution of the pneumopericardium and pneumomediastinum. The patient was encouraged to continue taking bronchodilators on a regular basis.

Discussion

Pneumopericardium occurring spontaneously during an acute asthmatic attack appears to be a rare phenomenon. A review of the English literature revealed only one



Lateral and posterio-anterior views of the chest taken at the time of admission reveal moderate pneumopericardium (open arrows) and pneumomediastinum (closed arrows). No other abnormalities were seen.

previous case.[1] Despite its rarity it is believed that the mechanisms leading to pneumopericardium are similar to those leading to other complications of asthma.[1-3] More specifically, we believe that pneumopericardium is a late complication of poorly managed asthma. Recurrent insult to the lung parenchyma results in ultimate weakening of the alveoli, pleura, and pericardium with breakdown of the tissue and the formation of adhesions and fistulae.[1,2,4,5]

Unlike pneumomediastinum, which is generally considered a benign condition,[2,6,7] pneumopericardium is potentially dangerous. The greatest fear is cardiac tamponade. The patient in this report showed signs of early tamponade, including tachycardia and a wide pulse pressure.

Treatment of asthma-induced, uncomplicated pneumopericardium is confined to the treatment of the underlying acute asthmatic condition.[1] Prevention is preferred, and is achieved by better management of asthma.

Acknowledgement

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DOCTOR'S NEWS

Physicians in the News

Dr. Hilde Osto, Chicago, has been elected president of the medical staff at Illinois Masonic Medical Center, Chicago. Dr. Osto, a family practitioner, received her medical degree from the University of Cologne in West Germany, joining the Illinois Masonic medical staff in 1958.

Other medical staff officers elected recently are **Dr. Richard Bloom,** Chicago, vice president, and **Dr. Branko Pavlovich,** Evanston. Dr. Bloom, a graduate of the University of Illinois, is the assistant program director of Illinois Masonic's internal medicine residency program and clinical assistant professor at the University of Illinois Abraham Lincoln School of Medicine. Dr. Pavlovich received his medical degree from the University of Geneva, Switzerland, and is a clinical assistant professor of cardiology at the Abraham Lincoln School of Medicine.

In addition, **Dr. Silviano Gomez,** Western Springs, has been appointed acting director of the Pediatric Ambulatory Care Center at Illinois Masonic. Dr. Gomez, who received his medical degree from the University of Salamaca in Spain, will be responsible for the clinical and operational management of the center.

Dr. Tien C. Cheng is the newly appointed president of the Taiwanese Association of America, Greater Chicago Chapter. A fellow of the American College of Cardiology and the American College of Physicians, Dr. Cheng is in private practice in Gurnee.

Dr. Alex S. Tulsky, Chicago, was recently presented with the "Torch of Learning Award" by the American Friends of the Hebrew University of Jerusalem. The presentation took place at the annual dinner of the organization's Chicago chapter, Wednesday, March 27, at the Westin Hotel. Dr. Tulsky is distinguished clinical professor, department of obstetrics and gynecology at the University of Illinois Abraham Lincoln School of Medicine, and senior attending obstetrician and gynecologist at Michael Reese Hospital.

Dr. Eugene Rogers, professor and chairman of the department of rehabilitation medicine at the Chicago Medical School, has been included in the 43rd edition of "Who's Who in America." Dr. Rogers, a fellow of the American College of Physicians, recently received the Literary Gold Key Club Award of St. Mary of Nazareth Hospital for his contributions to medical journals and the five-year service award from the Chicago Medical Society.

Dr. Donald F. Steiner, Chicago, is to receive the 1984-85 Wolf Foundation Prize for Medicine for his research on insulin. The Israel-based international award in medicine is honoring Dr. Steiner for ". . . discoveries concerning the biosynthesis and processing of insulin which have had profound implications for basic biology and clinical medicine." Dr. Steiner is associate director of the University of Chicago Diabetes and Research Training Center, and the University's A.N. Pritzker Professor of Biochemistry and Medicine. The award will be presented by the president of Israel in May before Israel's Knesset (Parliament) in Jerusalem.

Morris T. Friedell, M.D., Chicago, recently received the Chicago Medical Society's eighth annual public service award. A former chairman of the ISMS Board of Trustees and former president of the Chicago Medical Society, Dr. Friedell was honored for his successful efforts to salvage and promote the once-failing Jackson Park Hospital on Chicago's South Shore. . . . **Anthony D. Ivankovich, M.D.,** Glenview, has been appointed to the William Gottschalk, M.D., endowed professorship in anesthesiology at Rush-Presbyterian-St. Luke's Medical Center. Dr. Ivankovich is professor and chairman of anesthesiology at the medical center as well as director of the Rush Pain Center. Dr. Gottschalk, for whom the award is named, was associate chairman of the department of anesthesiology until his sudden death in October, 1984.

Copley Memorial Hospital, Aurora, has announced newly elected medical staff officers. **James A. Sandrolini, M.D.,** Aurora, has been elected chief of staff. **James R. Downing, M.D.,** Aurora, will serve as vice chief. **Daniel E. Susmano, M.D.,** Aurora, was named secretary-treasurer. . . . **Fedele Morelli, M.D.,** Oak Park, has been appointed medical director for Gottlieb Memorial Hospital in Melrose Park.

Rabies Vaccine Recalled

Wyeth Laboratories is recalling from the market all supplies of its Wyvac® Rabies Vaccine. According to a release from Wyeth, the Center for Disease Control recently brought to their attention recent studies of serologic responses which suggest that antibody response after rabies postexposure prophylaxis provided by the product is suboptimum. Wyeth is recommending a booster for persons potentially exposed to rabies since October 15, 1984, who received postexposure prophylaxis. Further information regarding this matter may be obtained by contacting Wyeth at 1-800-321-2304.

MEMBERSHIP FORUM

Membership Forum is intended to serve as a communication tool for ISMS membership. The editors encourage comment and criticism on issues of the day. Material published in this section reflects the personal opinions of individual ISMS members. ISMS cannot accept responsibility for content. Publication does not reflect official policy or position of the Illinois State Medical Society or the Illinois Medical Journal. The right to edit materials, which should be limited to 300 words or less, is reserved.

Correspondence should be addressed to: IMJ, Twenty N. Michigan Ave., Suite 700, Chicago 60602.

A Correction

Dear Sir:

I have received a communication from the Kaiser Permanente Medical Care Foundation concerning my article, "Capitalist Medicine—the American Way?" published in the September, 1984, issue of the *Illinois Medical Journal.* (166:3, 161-165, September 1984). In it, reference is made to the Kaiser Foundation being a staff model HMO. Kaiser is, in fact, a prepaid group practice model. I hope your readers will take note of this correction.

Sincerely,
Jane Jackman, M.D.
Springfield

An Invasive and Costly Procedure?

Dear Sir:

In the June 1984 issue of the *Illinois Medical Journal* the "EKG of the month" section (165:6, 416, 435, June 1984) presented a case of an obvious anterior myocardial infarction. The text makes it quite clear that the patient was in shock and congestive heart failure. He also had a history of a previous myocardial infarction. As such we must take issue with the statement that "a coronary arteriogram would be helpful here." The only use for a coronary arteriogram would be in preparation for possible coronary bypass surgery. In this patient with an ejection fraction of 12%, which could have been determined noninvasively, coronary bypass surgery would not be indicated. Intracoronary streptokinase would not be of value in the presence of a previous myocardial infarction and severely impaired left ventricular function. There is certainly no diagnostic problem given the electrocardiogram, enzymes, and clinical picture presented. We fail to see the benefit of an invasive and costly procedure in this patient.

Sincerely,
Edward P. Rose, M.D.
Larry E. Alves, M.D.
Belleville

The Editor Replies:

Drs. Alves and Rose raised several important points with regard to the June, 1984, ECG of the Month. They are correct when they diagnose an acute anteroseptal wall myocardial infarction. However, the patient was not in obvious shock. He was in congestive heart failure, however. Cardiogenic shock is a result of severe left ventricular dysfunction due to myocardial infarction where the cumulative volume of infarcted tissue exceeds 40% of the left ventricle. The patient is often restless, confused, occasionally stuperous. He has cool, moist skin. The peripheral pulses are thready and rapid. There is diminished or absent urinary output. As a general rule, cardiogenic shock requires more than dobutamine, as was used in this case. The low blood pressure requires pressors such as dopamine and, more often, norepinephrine. Many studies have demonstrated the efficacy of the intra-aortic balloon counterpulsation as the treatment of choice to support the circulation of these severely ill patients. Our patient had congestive heart failure and hypotension which responded well to fluid management and dobutamine. The dose of dobutamine kept the blood pressure at a systolic of 100 to 110mmHg by improving cardiac contractility. Dobutamine at usual doses has no pressor effect and, in fact, may lower systemic vascular resistance.[1] The previous myocardial infarction makes this patient a high risk candidate for the sudden death syndrome, particularly since his ejection fraction is less than 40% and he has ventricular arrhythmias.[2] The use of intracoronary streptokinase in the setting of

acute myocardial infarction is still experimental. It remains to be seen whether or not significant survival can be accomplished with the use of streptokinase in the early hours after the onset of infarction. If our efforts are to preserve as much viable myocardium as possible, streptokinase might be more useful in the setting of an old myocardial infarction since it could be started intravenously as well as intracoronary. The use of streptokinase, though, is still not determined. Eventually, it may be the first step in the management with the second step to include coronary angioplasty or emergency aortocoronary bypass surgery. No data is available on these points at this time. The use of a tissue-type plasminogen activator which selectively dissolves any thrombus in the arterial system may be the answer we are looking for. These treatments are still under study.

One of the main points that Drs. Rose and Alves make has to do with the indications for coronary arteriography. They specifically take issue with the statement that a "coronary arteriogram will be helpful here." The primary purpose of coronary arteriography is to determine the presence, the severity of coronary artery disease and the adequacy of left ventricular function. Dr. Gensini has said it well: "to state that coronary arteriography should be performed only to decide on the possibility of coronary bypass surgery would seem to be akin to stating that an electrocardiogram should be performed only to decide whether or not a patient should be admitted to a coronary care unit."[3]

There is no doubt that the indications for coronary angiography do vary somewhat. An ad hoc committee of the American Heart Association has spelled out specific indications for coronary angiography. These would include our patient, in addition to those patients that have symptomatic post-myocardial infarction, complicated acute myocardial infarction, as well as resuscitation from cardiac arrest not associated with myocardial infarction. Adequate laboratory facilities and skilled angiographers are absolutely necessary.[4] If the coronary arteriogram demonstrates technically bypassable coronary arteries, the presence of left ventricular dysfunction or low ejection fractions would suggest that aortocoronary bypass surgery prolongs the life of these patients. A statistically significant difference in survival suggesting benefit from surgical treatment was found in the Veteran's Administration coronary artery bypass surgery cooperative study. In other words, the sickest patients derived the greatest benefit. Patients with normal left ventricular function and low angiographic risk, as they defined it, did not show statistically significant advantage with bypass surgery.[5]

There is no question that this is an invasive and costly procedure. The benefit is relief of angina and apparent prolongation of life at least in the short term of five to seven years follow-up. The only alternative to this costly and aggressive approach to the treatment of coronary artery disease is to allow the natural history to take its usual, well-documented, disasterous course.

I would like to thank Drs. Alves and Rose for taking the time to write about one of our EKG of the Month columns.

John F. Moran, M.D.
Contributing Editor

References

1. Tuttle and Mills: "Dobutamine. Development of a New Catecholamine to Selectively Increase Cardiac Contractility," *Circ Res* 36:185, 1975.
2. Mukharji J., *et al.*: "Risk Factors for Sudden Death After Acute Myocardial Infarction: Two Year Follow-Up.," *Amer J Cardiol* 54:31, 1984.
3. Gensini G.G., "Coronary Arteriography" Chapter 10, HEART DISEASE, Eugene Braunwald, ed., W. B. Saunders Company, Philadelphia, 1984.
4. Boucek R. J., *et al.*: CORONARY ARTERY DISEASE PATHOLOGIC AND CLINICAL ASSESSMENT, Chapter 16. Williams and Wilkins, Baltimore, 1984.
5. Veteran's Administration Coronary Artery Bypass Surgery Cooperative Study Group: "Eleven Year Survival in the Veteran's Administration's Randomized Trial of Coronary Artery Bypass Surgery for Stable Angina," *NEJM* 311:1333, 1984.

Biography Prompts Comment

To the Editor:

May I add my compliments to the many that you have received for the magnificent biography of Dr. Max Thorek. (Romm, Sharon: "Max Thorek: Biographical Notes," 166:5, 331, 353, November 1984.)

This great physician and surgeon knew me from birth on, and later inspired me to bring many countries into the International College of Surgeons. His wife was a great lady, and did much for the medical profession. I have known his son Philip, who is such a great credit to his parents and to American medicine, during practically all our lives; since we are contemporaries.

Sincerely yours,
Roland I. Pritikin, M.D.
Rockford

As Does Second Opinion

TO: IMJ
RE: Emerson Goodwins

I enjoy this man's comments very much. Hope he continues his incisive philosophical musings, and that they'll be included in the *Journal.*

Sincerely,
Ben E. Wagner, M.D.
Riverside

PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

BLOOMINGTON:
Internal Medicine—To join an active six member IM practice in mid-western university community. A sub-specialty in Rheumatology, Endocrinology, or Allergy is desirable, but not necessary. Contact: J. Buchanan, The Health Center, 702 N. East St., Bloomington 61701 (309-827-5051). (2)

BRADFORD:
Family physician wanted to take over 32 years of well established rural practice with office and house—reason retirement. 120 bed equipped hospital 20 minutes drive, 35 miles from major medical and educational center. Elementary and high school 2 blocks from home. Contact (309) 897-8181. (6)

FAIRFIELD:
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FRANKFORT:
Multi-specialty group thirty miles southwest of Chicago seeks board elegible obstetrician-gynecologist to join expanding practice. Incentive plan, profit-sharing, relatively new building. Excellent practice opportunity with above average grade and high schools. Contact Howard Osmus, Administrator, Hedges Clinic, Frankfort, Il. 60423. (815-469-2123) (2)

KANE COUNTY:
Experienced occupational health physician needed to direct medical porgram in manufacturing plant in Southwest Suburbs. Call regional medical director (312)981-2195. (4)

ROCK ISLAND:
Internist group looking for a fourth physician to join growing area of Illinois Quad Cities. General internist and/or internist with sub-specialty willing to practice some general internal medicine. Offering financial guarantees and free rent for first year. Contact: Greg Romans, 2701 17th Street, Rock Island, IL 61201. (3)

SAYBROOK
Family practitioner—Excellent opportunity in east central Illinois; large modern office available; rural setting near modern well equipped community hospital; community is within twenty minutes of major universities, tertiary care centers; metropolitan area with major shopping, recreational and cultural activities available; financial incentives possible. Contact William Stack (309) 475-3521. (3)

VANDALIA
Specialists wanted. Family practice, internal medicine, pediatrics, general surgery, ENT, orthopedic surgery. One year guarantee with free office space. Needed for 92 bed acute, 134 bed LTC hospital in southern Illinois. Market covers 25,000+ people. Single office or clinic setting possible. Contact: Darrell Pile, Adm., Fayette Co. Hospital, Taylor Street, Vandalia, 62471 (618) 283-1231. (3)

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Additional diagnostic information on page 304

MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

The *Annals of Internal Medicine* report the first case of a granulomatous panniculitis in a 26 year old female secondary to the ingestion of the aspartame sweetener. Aspartame had been approved for use as a sweetener except for patients with phenylketonuria. This panniculitis subsided spontaneously upon discontinued use of aspartame within four weeks, possibly indicating an idiosyncratic reaction. Several unconfirmed reports of "dermal eruptions" and urticaria have been reported by the manufacturer. (Novick, N.L.: *Ann Int Med* 102:2,206-7, 1985)

In recent years, two antimicrobial agents have been shown useful in minimizing travelers diarrhea in travel to endemic areas. Doxycycline and trimethoprime sulfamethazole are 70-95% effective. Approximately 3-5% of persons taking antimicrobial agents will develop an objectionable side effect-most commonly a skin rash. A photosensitivity reaction has also been reported in association with doxycycline. Resistance and urinary tract infections may also occur. (Dupont, H. L. *et al: Ann Int Med.* 102:2,260-1, 1985)

Black Americans are at greater risk of hypertension with the use of alcohol irrespective of dose-effect. Health care counseling and education, especially in hypertensive and borderline hypertensive black patients, should be modified for regular screening and monitoring of alcohol consumption patterns. (Livingston, I.L.: *J N Med. Ass.* 77:2,129-135, 1985)

In most cases, the nerve roots involved in diagnoses of sciatica are readily identified. The authors evaluated the use of lumbar nerve root injections in those cases where delineation of the roots was difficult. In 19 cases studied by this method, multiple levels of involvement were noted in six. In two cases the myelograms were nondiagnostic and in three cases with positive myelographic evidence no neurologic deficits were noted. In four cases the results of the nerve root injections changed the treatment plan. (Bundens, D.A., Rechtine, G.R.: *Orthoped. Rev.* 14:2,45-9, 1985)

Medically directed home rehabilitation is suggested as a method of reducing costs and increasing the availability of rehabilitating low risk survivors of acute myocardial infarction. This technique proved equally effective when contrasted to a group therapy supervised regimen. Adherence to an individually prescribed exercise program was equally high at 71%, and the functional capacity was equally large at 1.8 ± 1.0 METS. The rate for nonfatal reinfarction and the drop out rate were equal at 3% or less. (DeBusk R. F., *et al: Am J Cardiol* 55:4, 251-7, 1985)

The authors report that dipyramidole-thallium imaging is a useful technique to assess cardiac risks in patients with severe peripheral vascular disease requiring surgery. It was found to be superior to clinical assessment and less expensive than coronary angiography. Complications were reported in 8 of 16 patients with abnormal imaging and none were reported in 32 cases with a normal dipyramidole-thallium redistribution imaging. (Boucher, C.A., *et al: N Engl J Med* 312:7, 389-394, 1985)

The *Morbidity and Mortality Weekly Report* (Vol 34 #1,1985) reports a 27% incidence of a papular, well-circumscribed rash in the upper extremities in cashiers, baggers and produce clerks handling celery in supermarkets. None occurred in shelf stockers, delicatessen clerks, meat clerks and managers. A diagnosis of phytophotodermatitis was made by the National Institutes of Occupational Safety and Health with the recommendation that produce handlers wash hands, wrists, and forearms regularly and avoid excessive exposure to sunlight.

Low back pain is a major cause of disability. Over 200,000 spine operations are performed and over 12 billion dollars are spent annually on low back problems. The author suggests that a CT scan of the back be performed and that myelography be reserved for those cases where the CT scan is equivocal and a tumor or other abnormality rather than disc is suspected. (Helms, C.A.: *Resid. & Staff Phys.* 31:1,51-63, 1985)

Society of Critical Care Medicine Presents its 14th Annual Symposium



Hyatt Regency Chicago May 21-25, 1985

CONTINUING EDUCATION UNITS have been approved by the Council for Continuing Medical Education (ACCME) Category I.
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Economic Issues; Critical Care Medicine in the 80's
Jeffrey A. Augenstein, MD, PhD

Pre-Operative Pulmonary Function Testing
Philip G. Boysen, MD

The Ventilator Dependent Patient: Medical & Social Care
Robert G. Kettrick, MD

Positive Airway Pressure: System Design & Clinical Application
Robert R. Kirby, MD

Treatment of Acute Myocardial Infarction, 1985
Charles Rackley, MD

Brain Resuscitation: 'Fact or Fancy'
Harvey M. Shapiro, MD

Transplantation
Thomas E. Starzl, MD, PhD

Management of Pain & Pain Related Problems in the Critically Ill Patient
Theodore H. Stanley, MD

Hypertensive Crisis in Critical Care
W. Leigh Thompson, PhD, MD

Trauma Critical Care Units: What Price Salvage?
Alexander Walt, MD

HEMODYNAMIC MONITORING WORKSHOP

PANELS

Critical Care Medicine and Nursing — Practice, Problems and Solutions
Frank H. Gafford, IV. MD, Chairman

Management of Critically Ill - Immunocompromised Patients
Joseph E. Parrillo, MD, Co-Chairman
Henry Masur, MD, Co-Chairman

Uniformed Services Scientific Section
Robert W. Taylor, MD, Head of Section

Cellular Mechanism of Acute Lung Injury: A Basis for Future Therapy for ARDS
Jean E. Rinaldo, MD, Chairman

Industry: a) Impact of DRG's on . . . W. Leigh Thompson, PhD, MD
b) Impact of Product Liability on . . . David Swedlow, MD
Judy Snyderman, MBA, Chairman

Does an Ounce of the Right Pre-Hospital Care Save a Ton of ICU Care — Which Interventions Really Make a Difference?
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Critical Care Research – Asking the Right Question
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Bart Chernow, MD, Chairman

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Harvey J. Sugerman, MD, Chairman

Positive Pressure Breathing Systems – Differences Do Exist!
Robert R. Kirby, MD, Chairman

Chronic Respiratory Failure in Infants and Children: A Medical/Societal Dilemma
Robert G. Kettrick, MD, Chairman

Trial for the Family Too

Malpractice Suit

By Nancy Hoffmann/ISMSA Twelfth District Councilor

You're being sued for malpractice. The news arrives via a summons from an officer of the court or a call from a newspaper or television reporter. The impact on the physician, spouse, and family is devastating, regardless of the merits of the case.

A physician has spent long years in education and training to be knowledgeable, secure and confident in dealing with patients and their families. The physician tries to give his best in all situations. The malpractice suit shakes that confident foundation and brings the doctor's world to a stop even if only for an initial few moments. The doctor begins to question himself, to feel shame, embarrassment, and guilt in response to the accusation. The doctor is concerned about how his patients will feel about him, how his practice will be affected, how other physicians will look at him and how he will deal with the legal aspects of the suit. The spouse and family are concerned about the physician's mental attitude, what they can do to help and how they can hold up with the added pressures of the suit.

Malpractice cases in Illinois have increased dramatically over the last few years. More and more physicians and spouses are struggling with the emotional stresses that the suits bring. Even though the first impulse is to hide and hope it will all go away, many physicians and spouses benefit from talking about their feelings and the stress that they are experiencing.

Last Spring, a physician in Winnebago County saw the need for a physician support group. Through the county medical society newsletter, volunteers were invited to meet and discuss the best ways to set up such a group. The group met several times to set purposes and guidelines. It was decided to keep the group as informal as possible to make physicians and spouses able to feel comfortable in asking for help. A panel was formed of concerned physicians and spouses who had been through the experience and were available on an individual basis to provide confidential assistance to anyone who might request it. The Physician Support Group established specific guidelines.

This program is not intended to deal with the merits (or lack thereof) of a particular "malpractice" case. Its purpose is to provide necessary emotional support and helpful information to physicians and spouses who are going through a malpractice suit.

Inquiries and contacts remain absolutely confidential with no identification of participants in any particular case being recorded.

The basis of this program is individual contact based on open and frank discussion. Enquirers may contact any panelist(s) he/she wishes. There is no group interraction as part of this program.

Panelists provide non-identifying reports to the medical society upon completion of their contact with a physician or spouse to enable statistical monitoring.

A brochure with an introduction of the group, the program guidelines and a list of the panel physicians and spouses was prepared with the help of the medical society staff. These brochures have been made available to all area physicians, hospital medical staffs, the Illinois State Medical Inter-Insurance Exchange, and other professional liability insurance carriers.

The medical society and auxiliary have worked closely to develop the Physician Support Group. They feel strongly that the malpractice problem affects both physician and spouse, and that by sharing concerns, fears, anger, and frustrations with other physicians and spouses who have been through the experience, the severity of stress and hardship can be lessened. ◂

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

MAY

Allergy

Annual Alan Feinberg Resident-Fellow Program, May 20, 1985, 8:00 p.m.
For: Primarily Allergists. Lectures, Holiday Inn Chicago City Centre. **Sponsor:** Illinois Society of Allergy and Clinical Immunology, 800 East Northwest Highway #101, Mount Prospect, Illinois 60056. **Fee:** $15.00 dinner. **Limit:** None. **Credit:** Category 1, 1 hour. **Contact:** Dianne K. Kubis. **Phone:** 312/255-1024.

Dermatology and Allergy Symposium.
For: Physicians, Surgeons, Staff. Symposium, May 15, 1985, 1:00-5:20 p.m. Nashville, Illinois. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, Illinois 62708. **Fee:** $45.00. **Credit:** Category 1:4 hours, AAFP Prescribed: 4 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** 217/236-7711.

Anesthesiology

Specialty Review in Anesthesiology
For: Anesthesiologists. Lecture, May 12-17, 1985, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Fee:** $670. **Reg. Limit:** None. **Credit:** Category 1: 54 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** 800/621-4649 in Illinois; 800/621-4651 outside Illinois.

Cardiology

Coronary Artery Disease and Sudden Death; Primary and Secondary Prevention.
For: Primary Care Audience. Workshop/Lecture, May 3-5, 1985. Chicago—Hyatt Woodfield Hotel. **Sponsor:** International Medical Education Corporation, 64 Inverness Drive East, Englewood, Colorado 80112. **Fee:** $295.00. **Limit:** 75. **Credit:** Category 1: 13 hours; AAFP Prescribed: 13 hours; AOA: 13 hours. **Contact:** Beverly Jacobsen. **Phone:** 800/525-8651, extension 273.

Diagnosis and Treatment of Thromboembolic Disease, 1985 Conference, May 16, 17, 18.
For: Physicians in patient care. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Building, 610 Walnut Street, Madison, Wisconsin 53705. **Fee:** N/A **Limit:** None. **Credit:** CEU's: 10 hours, Category 1: 10 Hours. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** 608/263-2856.

Second Biennial Chicago Cardiovascular Symposium.
For: All Physicians. Course, May 8-10, 1985. Chicago, Illinois. **Sponsor:** American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104. **Fee:** N/A **Limit:** N/A **Credit:** Category 1: 15 hours. **Contact:** Maxine Topping, Section Chief. **Phone:** 215/243-1200.

Obstetrics/Family Medicine

Controversies in Family Medicine/Low Intervention Obstetrics
For: Family Practitioners, Obstetricians, Obstetric Nurses, Nurse Practitioners, Physician Assistants. Conference, May 21-23, 1985. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut Street, Madison, Wisconsin, 53705. **Co-Sponsor:** Department of Family Medicine and Practice, School of Medicine, University of Wisconsin. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 11 hours; Other: University of Wisconsin-Extension CEUs: 11 hours; AAFP Prescribed: 11 hours; AOA: 11 hours. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** 608/263-2856.

Plastic Surgery

Plastic Surgery in Primary Care
For: Primary Care and Emergency Physicians. Conference, May 17, 1985, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut Street, Madison, Wisconsin, 53705. **Co-Sponsor:** University of Wisconsin School of Medicine; Division of Plastic Surgery. **Fee:** $140, MD, DO. **Reg. Limit:** None. **Credit:** Category 1: 6 hours; AAFP Prescribed: 6 hours; AOA: 6 hours. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** 608/263-2856.

Pathology

Modern Methods of Diagnosis in Tumor Pathology, Slide Seminar.
For: Pathologists. May 13, 1985, 7:00 p.m. Drake Hotel, Chicago, Illinois. **Sponsor:** Chicago Pathology Society. **Fee:** For dinner. **Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall H. Short, M.D., Loretto Hospital, 645 South Central Avenue, Chicago, Illinois.

Pediatrics

Specialty Review in Pediatric Cardiology
For: Pediatric Cardiologists. Lecture, May 28-31, 1985, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Fee:** $475. **Reg. Limit:** 90. **Credit:** Category 1: 32 hours. **Contact:** Robert J. Baker, M.D., Dean, 800/621-4649 in Illinois; 800/621-4651 outside Illinois.

Psychiatry

Comprehensive Psychiatry Review Part II: The Psychiatric Interview.
For: Psychiatrists. Course, May 17-19, 1985. Chicago, Illinois. **Sponsor:** The University of Chicago, 5841 South Maryland, Box 139, Chicago, Illinois 60637. **Fee:** $375.00. **Limit:** None. **Credit:** Category 1: 17 hours. **Contact:** Mary Ann Dillon. **Phone:** 312/962-1056.

Surgery

Flexible Fiberoptic Sigmoidoscopy
For: Surgeons. Lecture, May 4, 1985, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Fee:** $145. **Reg. Limit:** 75. **Credit:** Category 1: 7 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** 800/621-4649 in Illinois; 800/621-4651 outside Illinois.

Advances in Surgery
For: General and Specializing Surgeons. Lecture, May 6-10, 1985, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Fee:** $540. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** 800/621-4649 in Illinois; 800/621-4651 outside Illinois.

Hair Replacement Surgery
For: Surgeons. May 15-19, 1985. **Sponsor:** Northwestern University Medical School. **Fee:** $675.00. **Contact:** J.B. Pinski, M.D., 55 East Washington Street, Chicago, Illinois, Suite 3404, for more information.

Neuroradiology

1985 Neuroradiology Review Course
For: General Radiologists, Neuroradiologists, Neurosurgeons, Neurologists, Residents. Course, May 4-5, 1985, Oakbrook Marriott Hotel, Oak Brook, Illinois. **Sponsor:** Loyola University Medical Center, 2160 South First Avenue, Maywood, Illinois 60153. **Co-Sponsors:** Linda K. Gunzburger, Ph.D., Dept. of CME; Behrooz Azar-Kia, M.D., Dept. of Radiology. **Fee:** $170/$100 for Residents. **Credit:** Category 1: 16 hours. **Contact:** Linda K. Gunzburger, Ph.D. **Phone:** 312/531-3237.

Neurology

Epilepsy Update "85"
For: Physicians. Lecture and Faculty Discussion, May 20, 1985, North Chicago Illinois. **Sponsor:** The University of Health Sciences/The Chicago Medical School, 333 Green Bay Road, North Chicago, IL. 60604. **Fee:** $50.00 Physicians; $25.00 Non-Physicians. **Reg. Limit:** None. Category 1: 5 hours. **Contact:** Charles E. Morris, M.D., Reuben R. Weisz, M.D. **Phone:** (312) 578-3333 and Ben B. Blivaiss, Ph.D.-CME. **Phone:** (312) 578-3215.

Family Medicine

Breast Cancer: Diagnosis and Treatment
For: Practicing Physicians. Symposium, May 10-11, 1985. St. Louis, Missouri. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO. 63110. **Fee:** $200.00. **Reg. Limit:** 150. **Credit:** 12 hours AAFP Prescribed; 12 hours AMA Category 1; 12 hours AOA. **Contact:** Loretta Giacoletto, Administrative Coordinator, **Phone:** 800/325-9862.

Clinical Aspects & Therapeutic Principles of Alzheimer's & Parkinson's Diseases
For: Practicing Physicians. Symposium, May 18, 1985, St. Louis, Missouri. **Sponsor:** Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO. 63110. **Fee:** $100. **Reg. Limit:** 150. **Credit:** 6 hours AAFP Prescribed; 6 hours AMA Category 1; 6 hours AOA. **Contact:** Loretta Giacoletto, Administrative Coordinator. **Phone:** 800/325-9862.

Osteoporosis: Pathophysiology, Nutrition and Treatment
For: Internists, Family Practitioners, OB/GYN, Endocrinologists, and Ortho Surgeons. Osteoporosis: Symposium, May 10, 1985, 8:00AM-5:00PM; May 11, 1985, 8:00AM-5:00PM. Chicago, Illinois. **Sponsor:** Rush University, Rush-Presbyterian-St. Luke's Medical Center, University Office of Continuing Education, 600 South Paulina, Chicago, IL. 60612. **Co-Sponsors:** Dairy Nutrition Council, Inc. **Fee:** $150.00. **Reg. Limit:** 220. **Credit:** 10 hours AAFP Elective; 10 Hours AMA Category 1; **Other:** ACOG, and American Dietetic Assoc. **Contact:** Barbara Trejo, Meeting Planner. **Phone:** (312) 942-7095.

Advances in Cancer Care
Lectures & Workshops, May 31, 1985 & June 1, 1985, Chicago, Illinois. **Sponsor:** Michael Reese Hospital and Portes Cancer Center, Michael Reese Hospital, Office of Continuing Medical Education, 31st & Lake Shore Drive, Chicago, Illinois. **Fee:** $100.00. **Reg. Limit:** None. **Credit:** 12¾ hours AAFP Elective. **Contact:** Michael E. Goldman. **Phone:** (312) 977-1000 or 791-3460.

Specialty Review in Family Practice
For: General and Family Practitioners. Lecture, May 28-June 8, 1985. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois, 60612. **Fee:** $725. **Reg. Limit:** 90. **Credit:** Category 1: 91 hours. Contact: Robert J. Baker, M.D., Dean. **Phone:** 800/621-4649 in Illinois. 800/621-4651 outside Illinois.

JUNE

Oncology

Controversies in Breast Cancer Treatment
For: Oncologists/Radiation Therapists/Surgeons/Family Practitioners. Course, June 12, 1985, Holiday Plaza Complex, Matteson, Illinois. **Sponsor:** The University of Chicago, 5841 S. Maryland Avenue, Box 139, Chicago, Illinois, 60637. **Fee:** $20. **Reg. Limit:** None. **Credit:** AAFP Elective 6 hours; AMA Category 1 6 hours. **Contact:** Marlene Goldberg, Conference Manager. **Phone:** 312/962-1056.

Obstetrics/Gynecology

Chicago Area Medical Schools Review Course in Obstetrics and Gynecology
For: Gynecologists. Course, June 10-15, 1985, Chicago, Illinois. **Sponsor:** The University of Chicago, 5841 South Maryland—Box 139, Chicago, Illinois, 60637. **Fee:** TBD. **Credit:** Category 1 32 hours; Other: ACOG 32 hours. **Contact:** Mary Ann Dillon. **Phone** 312/962-1056.

Pathology

Flow Cytometry and Immunohistochemistry in Diagnosis of Hematologic Malfunction
For: Pathologists. Symposium, June 10, 1985, Drake Hotel, Chicago, Illinois. **Sponsor:** Chicago Pathology Society, Marshall H. Short, M.D., Loretto Hospital, 645 S. Central Avenue, Chicago, Illinois, 60644. **Co-Sponsor:** Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall H. Short, M.D. **Phone:** 312/626-4300, Ext. 5720.

Pharmacology

Prediction of Drug Levels and Drug Monitoring
For: Primary Care Practitioners. Conference, June 6-7, 1985, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut Street, Madison, Wisconsin, 53705. **Co-Sponsor::** University of Wisconsin, School of Medicine, Department of Medicine; University of Wisconsin Hospitals and Clinics. **Reg. Limit:** None. **Credit:** Category 1: 12 hours; Other: University of Wisconsin-Extension CEU's; AAFP Prescribed: TBD hours; AOA: TBD hours. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** 608/263-2856.

Surgery

Medical and Surgical Review of Reflux Esophagitis and the Angelchik Prosthesis
For: Surgeons, Primary Care Physicians. Conference, June 14-15, 1985, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut Street, Madison, Wisconsin. **Co-Sponsor:** University of Wisconsin, School of Medicine, Department of Surgery. **Fee:** $200. **Reg. Limit:** None. **Credit:** Category 1: 11 hours; Other: University of Wisconsin-Extension CEU's. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** 608/263-2856.

Relaxation/Fitness

Corporate and Industrial Wellness
For: M.D.'s, R.N.'s, O.T.'s, Administrators, Dietitians and Health Care Professionals. Workshop, June 10-13, 1985, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Philip K. Wilson, Ed. D., La Crosse Exercise Program, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse, Wisconsin, 54601. **Co-Sponsor:** La Crosse Lutheran Hospital/Gundersen Clinic, Ltd. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; Other: 3.5 CEU's from Community Health, UW-La Crosse, Extended Education/UWEX; AAFP Prescribed: 35 hours.

Teaching Stress Management and Relaxation Skills
For: M.D.'s, R.N.'s, P.T.'s, O.T.'s, Administrators, Dietitians and other Health Care Professionals. Workshop, June 2-7, July 14-19, November 10-15, 1985, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Room 221 Mitchell Hall, University of Wisconsin-La Crosse, La Crosse, Wisconsin, 54601. **Co-Sponsor:** La Crosse Lutheran Hospital/Gundersen Clinic, Ltd. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; Other: 3.5 CEU's from Community Health, UW-La Crosse, Extended Education/UWEX; AAFP Prescribed: 35 hours.

October 11-12, 1985
Thirteenth Annual ICCME Congress:
"Self-Directed Learning—The Gold Standard"
The focus of the Congress will be to explore various alternatives to traditional CME and investigate resources available to structure individualized CME according to the principles of adult education.
Keynote Speakers: Robert K. Richards, Ph.D.
Assistant Dean and Associate Professor
Michigan State University/College of Human Medicine
Executive Vice President
Grand Rapids Area Medical Education Center
Grand Rapids, Michigan

Alan B. Knox, Ph.D.
Professor of Continuing and Vocational Education
University of Wisconsin
Madison, Wisconsin
Place: Arlington Park Hilton
Arlington Heights, Illinois
Small group participative workshops will deal with the establishment of sound educational needs, goals, objectives and evaluation criteria and their application to CME.
For additional information, contact the Illinois State Medical Society, Division of Education, Twenty N. Michigan Ave., Suite 700, Chicago, IL 60602 (312) 236-6110.

Fitness and Weight Control
For: M.D.'s, R.N.'s, P.T.'s, O.T.'s, Administrators, Dietitians and other Health Care Professionals. June 3-7, July 22-26, 1985. **Sponsor:** La Crosse Exercise Program Education Services Unit, Room 221 Mitchell Hall, University of Wisconsin-La Crosse, La Crosse, Wisconsin, 54601. **Co-Sponsor:** La Crosse Lutheran Hospital/Gundersen, Ltd. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; Other: 3.5 CEU's from Community Health, UW-La Crosse, Extended Education/UWEX; AAFP Prescribed: 35 hours.

Orthopedics

Specialty Review in Orthopedic Surgery
For: Orthopedic Surgeons. Lecture, June 9-15, 1985, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. 60612. **Fee:** $650.00. **Reg. Limit:** 90. **Credit:** Category 1: 68 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649 in Illinois, (800) 621-4651 outside Illinois.

Surgery

Peripheral Nerve Injury and Repair: The Practical Aspects
For: Surgeons. Lecture & Laboratory Workshop, June 27-29, 1985, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Fee:** $1000.00 **Reg. Limit:** 90. **Credit:** Category 1: 28 hours **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649 in Illinois, (800) 621-4651 outside Illinois.

Internal Medicine

Neoplasms of the Alimentary Tract: Current Concepts in Diagnosis and Therapy
Symposium, June 14-15, 1985, Springfield, Illinois. June 14th—8:00AM-4:00PM, Sheraton Inn; June ,15th—8:00AM-9:00AM, Memorial Medical Center. **Sponsor:** Springield Clinic, 1025 S. Seventh Street, Springfield, IL. 62703. **Fee:** $25.00. **Reg. Limit:** None. **Credit:** Category 1: 9 hours. **Contact:** Betty Green, R.N., Springfield Clinic, 1025 S. Seventh St., Springfield, IL. 62703. **Phone:** (217) 528-7541.

Plastic Surgery

Practical Plastic Surgery
For: Physicians, other medical professionals. Symposium, June 4, 1985, 6:00PM-10:00PM, Alton, Illinois. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springield, Illinois 62708. **Fee:** $25.00. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** (217) 782-7711.

Genetics

Genetic Disorders
For: Physicians, other medical professionals. Symposium, June 13, 1985, 3:00PM-7:00PM, Quincy, Illinois. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, Illinois 62708. **Fee:** $25.00. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** (217) 782-7711.

Critical Care Medicine

Critical Care Medicine: A Review of Current Practice
For: Critical Care Physicians, Surgeons, Primary Care Physicians and Anesthesiologists. Lecture, June 10-15, 1985, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Fee:** $610.00. **Credit:** Category 1: 54 hours; **Other:** 54 Prep Credits. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649 in Illinois, (800) 621-4651 outside Illinois.

Affective Disorders

Anxiety Disorders—1985 Update
For: Psychiatrists, Psychologists and Health Care Professionals. Lectures/Workshops, June 28-29, 1985, Wisconsin Center, Madison, Wisconsin. **Sponsors:** Anxiety Disorders Center, University of Wisconsin Department of Psychiatry, and University of Wisconsin-Extension, Department of Continuing Medical Education. **Fees:** $200.00 for physicians and health care professionals; $100.00 for residents and trainees. **Credit:** AMA Category 1—10 hours; University of Wisconsin Continuing Education Units—1.0. **Contact:** Dorothy B. Davidson, Ph.D., Program Coordinator, Anxiety Disorders Center, Department of Psychiatry, University of Wisconsin Hospitals and Clinics, 600 Highland Avenue, Madison, Wisconsin 53792. **Phone:** (608) 263-6129.

JULY

Psychiatry

Special Marriage Enrichment
Symposium, July 13, 1985—1:00PM-6:00PM, Maywood, Illinois 60153. **Sponsor:** Loyola University Department of Psychiatry, 2160 South First Avenue, Room 3601, Maywood, IL. 60153. **Fee:** $30.00 per person. **Reg. Limit:** 60. **Credit:** Category 1: 5 hours; AAFP Elective: 5 hours. **Contact:** Domeena C. Renshaw, M.D. **Phone:** (312) 531-3752.

Commitment to Professional Development

If your medical assistant is a "Perfect 10" don't bother to read any further. If you are a physician associated in a large or small clinic group you may employ a business manager who hires the professional people who work for you. Please direct this article to that person. I am primarily addressing my remarks to those physicians who employ up to 10 medical assistants.

Doctor, I am aware of the fact that you have trained your personnel in the clinical aspects of your office routine. I am reasonably sure that your medical assistant knows her job responsibilities. However, my question is this: Are you spending more time in the office and enjoying it less? Are you really satisfied with your medical assistant's job performance? Is your medical assistant as knowledgeable as she should be about good office practices or credit and collection procedures? What about your Medicare and Medicaid receivables, are they under control? Is your cash flow as good as it should be?

If you have answered *no* to one or more of the above questions, consider what membership in the American Association of Medical Assistants can do for your staff. The Illinois Society, AAMA, can make the difference. Our organization is dedicated to improving medical assistants educationally and professionally. We can help your staff develop their skills. Courses in anatomy and medical terminology, physiology, professional law and ethics are offered and are taught by professionals with excellent qualifications and credentials. Our Medicare and Medicaid workshops, personal development seminars, and lectures by your physician colleagues at our monthly meetings can and will make a difference in your office climate.

Encourage your medical assistant to invest in her future. Don't accept the excuse that she "doesn't have the time," or that her "family responsibilities are too great." (Her husband and children will cooperate and she can manage her time.) Doctor, you have invested a great deal of time and money developing your own career and practice. Consider paying the dues in our professional organization as a bonus or fringe benefit or just as an incentive to get her thinking in a different perspective.

If a professional career is what your medical assistant is looking for and excellence is what you're looking for, I am offering you the solution. Membership in the Illinois Society, AAMA, is the best investment either of you will ever make.

Further information about the Illinois Society, AAMA, may be obtained by contacting one of the officers: Anna Cannon, EMT-A, president, 7443 S. Luella, Chicago, IL 60649; Betty J. Kronemeyer, CMA, immediate past president, 809 N. 10th, Mascoutah, IL 62258; Ehlma Garcia, CMA-EMT, president-elect, 6134 S. Tripp, Chicago, IL 60629; Cheryl Hutchinson, CMA, first vice president, 53 Lockhaven, Granite City, IL 62040; or Betty Jean Meier, second vice president, 2812 Barber Green Rd., DeKalb, IL 60115. ◂

Anna Cannon, EMT-A
President
Illinois Society, AAMA

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6 insertions	20.00	26.50	46.00	66.00
12 insertions	33.00	44.00	77.00	110.00

All proposed advertisements should be received by the tenth of the month preceding publication. A surcharge of $2 will be assessed when a box number is requested.

POSITIONS AND PRACTICE

EXCELLENT OPPORTUNITY for family physician to join growing northside medical group. Equity position in medical corporation available. No OB or Surgery. Membership on university affiliated hospital staff assured. Compensation $60,000 including benefits. Reply with resume to Box #1143, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

MULTI-SPECIALTY GROUP thirty miles southwest of Chicago seeks board eligible obstetrician-gynecologist to join expanding practice. Incentive plan, profit-sharing, relatively new building. Excellent practice opportunity with above average grade and high schools. Contact Howard Osmus, Administrator, Hedges Clinic, Frankfort, IL 60423, (815-469-2123).

EMERGENCY MEDICINE—Illinois and Missouri. Full and part time positions available in emergency departments and clinics for qualified physicians seeking lucrative employment opportunities. Outstanding remuneration and comprehensive malpractice insurance provided. For further information contact Amy Eisenman, Staffing Specialist. National Emergency Services, Inc., 1 Hollow Lane, Suite 304, Lake Success, New York 11042 or call (800) 645-4848.

EENT PRACTICE FOR SALE—Chicago and south suburbs. Single or multiple offices. High volume office practice; unusual opportunity. Outstanding locations. Please reply to Box 1157, c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602.

OPHTHALMOLOGIST AND ENT physician wanted part time for busy office. This is an unusual opportunity with excellent potential. South suburban Chicago area. Call 312-598-3131.

U.S. AIR FORCE MEDICAL CORPS currently is accepting applications for physicians in the following specialties: Surgery (all specialties), Obstetrics/Gynecology, Otorhinolaryngology, Anesthesiology, Psychiatry, Orthopedic Surgery, Cardiology, Allergist, Family Practice, and Internal Medicine. For further information call collect: Captain Brian Legg, (312) 263-1207.

INTERNAL MEDICINE: Full-time opportunities available for board eligible or board certified physicians for busy inpatient internal medicine department of south Florida hospital. Clinic positions also available in Tampa, Palm Beach and Miami. Send C.V. to Fern Blum, EMSA, 8200 W. Sunrise Blvd, Building C, Plantation, Florida, 33322 or call 305/472-6922.

AMBULATORY CARE/FAMILY PRACTICE Center—Family practice/primary care physician to associate in rapidly expanding center. Opportunity for hospital and outpatient care in metropolitan area of 400,000 in eastern Iowa. Guarantee with profit sharing available. Contact J. Koehler, M.D., East Kimberly Urgent Care Center, 2120 East Kimberly Road, Davenport, Iowa 52807, (319) 359-1301.

STUDENT HEALTH. Opening available July 1985 for primary care internist, family physician or pediatrician. Full-time 10 or 11-month position. Competitive salary and benefit package, 40-hour work week. Illinois license, board eligibility/certification, and interest in some gynecology required. Contact: Paul Nelson, MD, Student Health Service, Illinois State University, Normal, Illinois 61761, (309) 438-8655. Applications accepted until May 1, 1985 or until suitable application pool obtained. An Affirmative Action/Equal Opportunity Employer.

FAMILY PRACTITIONER—for multispecialty medical building in Valparaiso, Indiana. Large referral base. Opportunity for lab and X-ray partnership and new building depreciation or lease. Contact Thomas Covey, M.D. (219) 462-4167 for details.

ORTHOPEDIC SURGEONS WANTED. Nationally respected organization which limits its activities to independent medical evaluations desires the services of board certified orthopedic surgeons in the Chicago area who are engaged in active practice. This is an excellent opportunity for the practitioner who seeks part-time forensic work as a supplement to treatment income. This is a unique setting in which all management and support functions are provided. Work schedules revolve around the physicians' requirements and availability. Please forward curriculum vitae to: J. Patrick Cohan, 14295 East Seven Mile Road, Detroit, Michigan 48205, or call (313) 527-4620.

GENERAL INTERNIST—for multispecialty medical building in Valparaiso, Indiana. Large referral base. Opportunity for lab and X-ray partnership and new building depreciation or lease. Contact Thomas Covey, M.D. (219) 462-4167 for details.

OB/GYN—for multispecialty medical building in Valparaiso, Indiana. Large referral base. Opportunity for lab and X-ray partnership and new building depreciation or lease. Contact Thomas Covey, M.D. (219) 462-4167 for details.

PHYSICIAN OPPORTUNITIES—Current openings for physicians of all specialities in the Illinois area and nationwide. Opportunities in solo, hospital and clinic based positions. For further information please contact Physician Recruiters Inc. at (312) 433-7180. All inquiries will be handled on a confidential basis.

ORTHOPAEDIC SURGEON with interest in Spinal Surgery to associate full/part-time with Chicago based Orthopaedic Group. Send C.V. to: Sports Medicine, Ltd. 6445 North Central Ave., Chicago, Ill. 60646.

FAMILY PRACTITIONER—Out-patient care. Full-time position available for residency trained, board eligible/board certified family practitioner interested in a position involving out-patient care. Pediatrics, pre-natal care, adult medicine, orthopedics and minor surgery responsibilities are available. For information, call Donald B. Dawson, Direc-

tor of Physician Staffing, toll-free at 1-800-446-2255, in California call 1-800-336-2255. FHP Professional Staffing, 400 Oceangate Blvd., Ste. 1317, Long Beach, CA 90802. For opportunities in Utah call Maryalys Poulson collect at 801-355-1234.

PHYSICIAN, UNIVERSITY HEALTH SERVICE. Assists in medical care, diagnosing and treatment of students, keeping proper records of their treatment. Assists the Director, assuming responsibility for staff supervision in his absence. M.D. degree required. Send letter of application to: Dr. Glenn D. Williams, Vice President for Student Affairs, Eastern Illinois University, Charleston, IL 61920 or call 217-581-3221 for more information.

CARDIOLOGIST—BOARD ELIGIBLE/CERTIFIED cardiologist needed. Should be proficient in catherization and implantation of permanent and temporary pacemakers. Both invasive and non-invasive experience preferred. For information, call Donald B. Dawson, Director of Physician Staffing, toll-free at 1-800-446-2255, in California call 1-800-336-2255. FHP Professional Staffing, 400 Oceangate Blvd., Ste. 1317, Long Beach, CA 90802. For opportunities in Utah call Maryalys Poulson collect at 801-355-1234.

HILTON HEAD, SC Primary care physician opening available at island resort's only extended hour medical center. Investment required. Submit CV to: Family Medical Center, P.O. Box 6598, Hilton Head, SC 29928.

EMERGENCY MEDICINE—ILLINOIS: Opportunity immediately available for career-oriented emergency medicine specialists to join newly formed group. Both medical director and full-time staff physician needed. Prestigious hospital with ultramodern ED, outstanding benefits. For details contact Susan Himburg, Decatur Memorial Hospital, 2300 No. Edwards, Decatur, IL 62526; 217-877-8121, ext. 3000.

INTERNIST—BOARD ELIGIBLE/CERTIFIED internist needed. Full range of in-hospital and out-patient work responsibilities. For information, call Donald B. Dawson, Director of Physician Staffing, toll-free at 1-800-446-2255, in California call 1-800-336-2255. FHP Professional Staffing, 400 Oceangate Blvd., Ste. 1317, Long Beach, CA 90802. For opportunities in Utah call Maryalys Poulson collect at 801-355-1234.

FAMILY PRACTICE PHYSICIAN—near central Illinois—Indiana border. Small community—small group—good coverage—replacing retired doctor, so instant patient load. Modern general hospital, trauma center—modern clinic nearby—board certified or eligible. Guarantee plus productivity. Safe, friendly community, variety fine housing, recreation opportunities abound. Please contact Box #1163, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602.

ILLINOIS: CHICAGO—Chairperson of Anesthesiology. Jackson Park Hospital, progressive 310-bed hospital. Must be board certified. Fee for service, minimum guarantee. Send CV to: John L. Burke, Associate Administrator, Jackson Park Hospital, 7531 Stony Island, Chicago, IL 60649. (312) 947-7779. Equal Opportunity Employer M/F.

ORTHOPEDIC SURGEON—FHP is seeking an orthopedic surgeon who has completed or is currently involved in a total arthroplasty fellowship, or an orthopedic surgeon with extensive experience in total joint replacement with particular reference to revision arthroplasty. For information, call Donald B. Dawson, Director of Physician Staffing, toll-free at 1-800-446-2255, in California call 1-800-336-2255. FHP Professional Staffing, 400 Oceangate Blvd., Ste. 1317, Long Beach, CA 90802. For opportunities in Utah, call Maryalys Poulson collect at 801-355-1234.

CENTRAL ILLINOIS PRACTICE For Sale, general surgery, oncology. Established for 8 years. Local population of 150,000 and draining area of 150,000. City with excellent hospitals, medical college and universities. Will introduce to the patients. Medical records and office furniture included. Reply Box 1162, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

DERMATOLOGIST WANTED for diagnosis and treatment of diseases of the human skin including skin injuries, infections, cysts and growths; requires M.D. in medicine and two years related experience as a resident in dermatology; $54,000.00 per year; 40 hours per week. Send resumes to Illinois Job Service, 910 South Michigan Ave., Room 333, Chicago, Illinois 60605. Attn: Dennis Doligala; Ref. #4025-D Employer paid ad.

UROLOGIST—BOARD ELIGIBLE/BOARD CERTIFIED urologist needed for busy surgical practice. Individual should have both adult and pediatric experience. For information, call Donald B. Dawson, Director of Physician Staffing, toll-free at 1-800-446-2255, in California call 1-800-335-2255. FHP Professional Staffing, 400 Oceangate Blvd., Ste. 1317, Long Beach, CA 90802. For opportunities in Utah, call Maryalys Poulson collect at 801-355-1234.

FAMILY PRACTICE position available at Stanley, Wisconsin. This physician would join an existing family practitioner in a hospital-affiliated satellite center of Marshfield Clinic, a major multispecialty referral center. The ideal candidate would enjoy practicing a full medical spectrum including obstetrics and pediatrics, would enjoy working in a modern clinic facility that is physically attached to a 41-bed community hospital, and would enjoy living in a small rural community only 30 minutes from Wisconsin's fastest growing metropolitan area. Starting salary $63 K plus extensive fringe benefits. Send curriculum vitae to: John P. Folz, Assistant Director, 1000 North Oak, Marshfield, Wisconsin 54449.

OPHTHALMOLOGIST, ILLINOIS: Long established general ophthalmology practice available 80 miles SW of Chicago (1½ hrs.). Good family location, excellent hospitals, high surgical volume, professional satisfaction, patient appreciation. New facility ready fall 1985. Owner will help phase in. Reply to Box #1152, c/o *Illinois Medical Journal*, Twenty N. Michigan Avenue, Suite 700, Chicago, IL 60602.

RADIOLOGIST WANTED—Rural community, Southeastern Illinois, 65 bed hospital has an opportunity for someone interested in low key life style requiring an average 20 hour work week. Please send C.V. to D.M. Blomgren, Administrator, Lawrence County Memorial Hospital, West State Street, Lawrenceville, Illinois 62439. Telephone number—618-943-2381.

DERMATOLOGIST, south suburb, 1 or 2 days a week. Facilities available, including laser therapy. Patient mix of HMO, IDPA, private. Reply to Box #1164, c/o *Illinois Medical Journal*, 20 North Michigan Avenue, Suite 700, Chicago, IL 60602.

SITUATIONS WANTED

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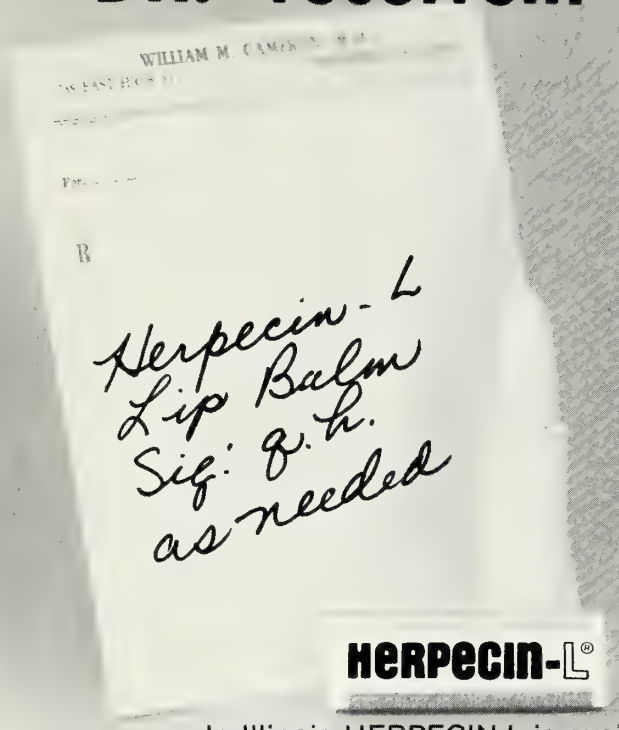
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Meeting the Challenge



My election to the presidency of the Illinois State Medical Society is simultaneously the greatest honor and the greatest challenge of my life. I accept this honor with all humility, and I pledge to serve the physicians of Illinois and our patients to the best of my ability. I will certainly need all of your best efforts to accomplish the goals of the medical profession and the Illinois State Medical Society.

The challenges posed to the medical profession during the mid-1980s are indeed coming from all directions. Frequently they come from outside the profession in the many forms of governmental intrusion. Often, laws and regulations are sweeping edicts that come from committees and subcommittees without public hearings, or they originate as amendments to non-germane bills without full legislative body consideration.

Fear of the Federal Trade Commission and its "anti-trust" charges have become pervasive and stifle honest efforts by medical societies to properly question practice, procedures and charges which are generally agreed upon. The indignant cries of industry and business about excessive medical costs have led to cost containment coalitions with and without medical expertise. There is a proliferation of HMOs, PPOs, IPAs, third party plans and hospital-sponsored plans, each marketing and advertising and spending huge sums of money to "get their market share."

Last, but not least, in these outside forces looms the thundercloud of our adversarial legal system ready to file the claim of a so-called "malpractice suit" usually without regard to any true negligence. This, in turn, fuels escalation of legal costs, massive increases in malpractice insurance premiums, defensive medicine costs, and the obvious resultant spiraling of health care costs. It is a situation in which everyone pays but nobody really wins.

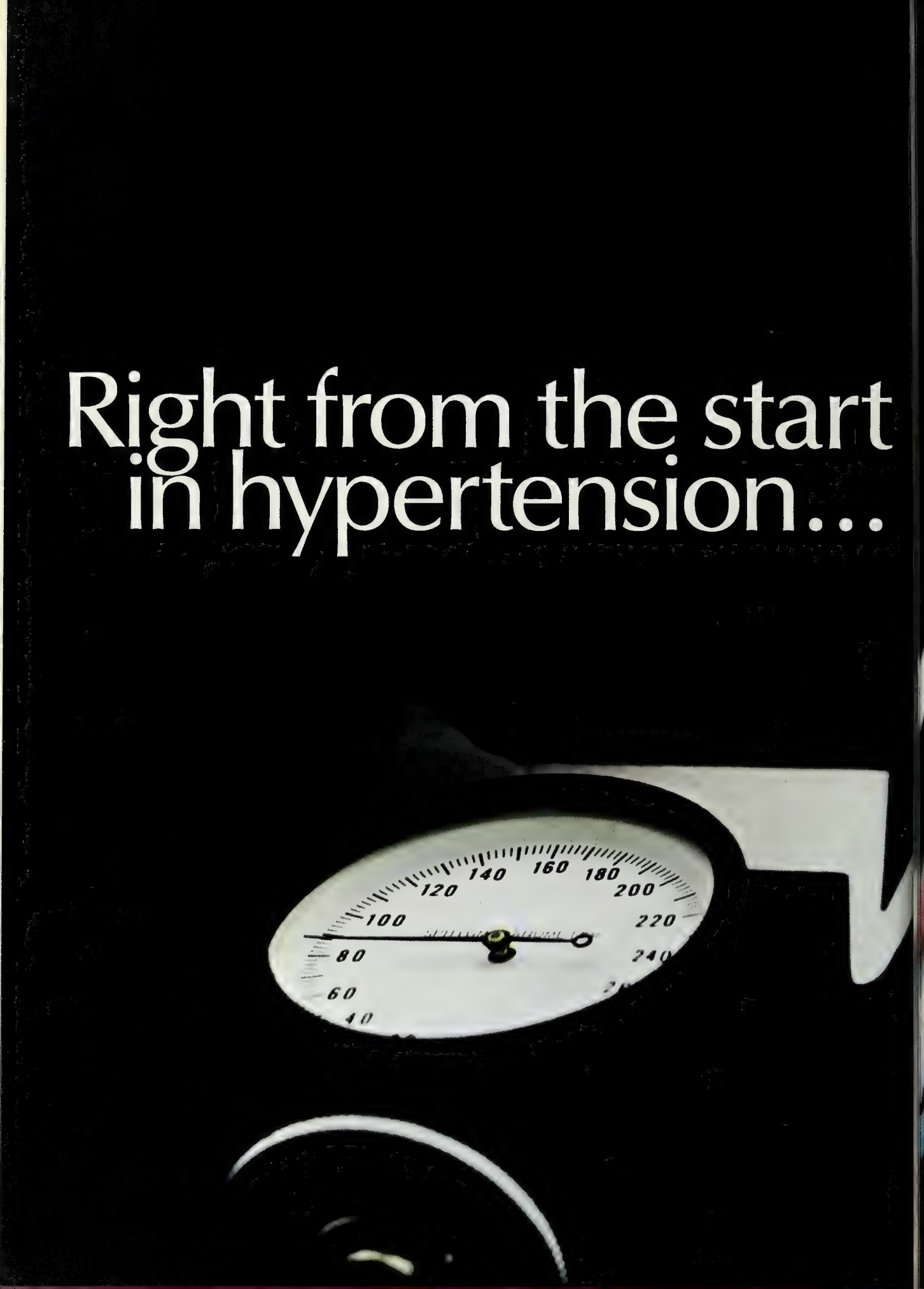
From *within* the profession, we have many who have not seriously considered the advantages of joining the efforts of organized medicine and paying their fair share to help all of us preserve our own professional freedoms and the freedoms of our patients to influence the type and direction of their care by choosing their own physician and hospital. We must individually and collectively convince our colleagues in medical schools, in industrial medicine, and in all forms of private practice, to join us in the struggle to preserve our freedoms to appropriately educate, train, do research, and practice medicine without the counterproductive smothering influence of ever-increasing bureaucracy.

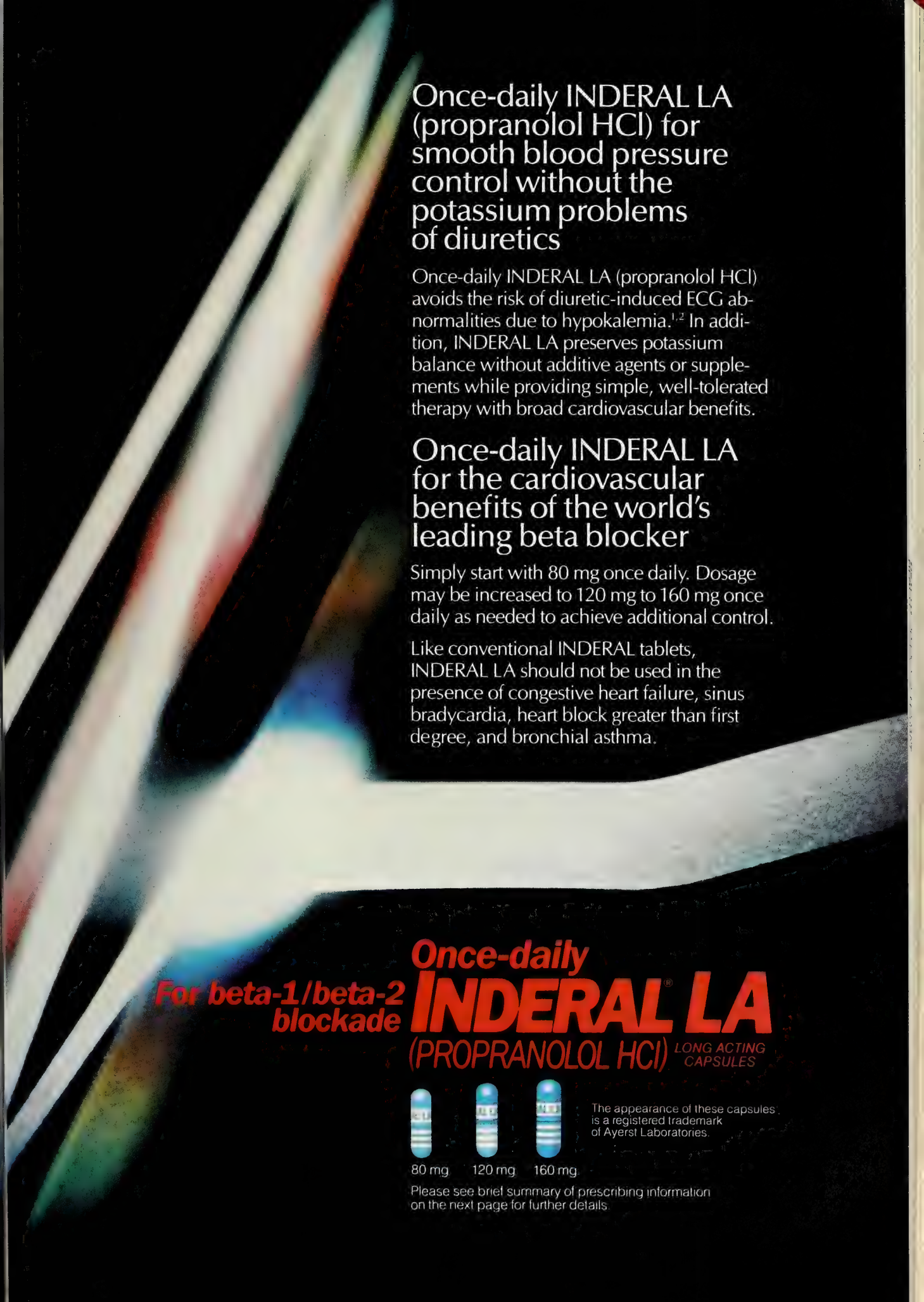
Physicians must remain resolute in their traditional role of patient advocacy and not allow these "business systems" to compromise and frustrate our primary goal of providing the best available quality patient care *in the kindest, most efficient and economical manner possible.*

Morgan M. Meyer

Morgan M. Meyer, M.D.
President

Right from the start in hypertension...





Once-daily INDERAL LA (propranolol HCl) for smooth blood pressure control without the potassium problems of diuretics

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Simply start with 80 mg once daily. Dosage may be increased to 120 mg to 160 mg once daily as needed to achieve additional control.

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

For beta-1/beta-2 blockade

Once-daily INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES

80 mg 120 mg 160 mg

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adhesive–
born to stay
on better
TRANSDERM-NITRO 5



Transderm-Nitro

nitroglycerin 24-hr systems: 2.5 mg, 5 mg, 10 mg, 15 mg

CIBA

Stays on better

Reformulated adhesive delivers optimum staying power. Results of two studies* with both placebo and active systems on normal subjects proved that Transderm-Nitro has an almost 100% adhesion rate, even under the most adverse conditions, including hot, humid summer weather.

Handles better

Clear plastic 3M backing is easy to remove — practically slides right off. There's no risk of your patient damaging the system. Especially easy to handle for elderly patients.

Comes off without significant irritation

The reformulated adhesive is strong, yet gentle on the skin. The studies* also showed no significant irritation after removal.

Contraindicated in patients with intolerance to organic nitrate drugs.

All transdermal nitroglycerin products are being marketed pending final evaluation of effectiveness by the FDA. (See Brief Summary of Prescribing Information on the next page.)

*Data on file, CIBA Pharmaceutical Co

Transderm®-Nitro

(nitroglycerin)
Transdermal Therapeutic System

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE INSERT)*

INDICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.

In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.

Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.

Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.

Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea, vomiting, and dermatitis. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued.

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.

The usual dosage is one Transderm-Nitro 5 system every 24 hours. Some patients, however, may require the Transderm-Nitro 10 system. If a single Transderm-Nitro 5 system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 systems or one Transderm-Nitro 10 system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone.

The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.

Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

HOW SUPPLIED

Transderm-Nitro System Rated Release *in vivo*	Total Nitroglycerin in System	System Size	Carton Size
2.5 mg/24 hr	12.5 mg	5 cm^2	30 Systems (NDC 0083-2025-26)
5 mg/24 hr	25 mg	10 cm^2	30 Systems (NDC 0083-2105-26)
5 mg/24 hr	25 mg	10 cm^2	7 Systems (NDC 0083-2105-07)
10 mg/24 hr	50 mg	20 cm^2	30 Systems (NDC 0083-2110-26)
15 mg/24 hr	75 mg	30 cm^2	30 Systems (NDC 0083-2115-26)

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C I B A
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Obituaries

Beverly, Bert Jr., Oak Park, died March 13, 1985 at the age of 63. Dr. Beverly was a 1951 graduate of Hahnemann Medical College and Hospital, Philadelphia.

****Cooper, Harry H.,** Chicago, died March 28, 1985 at the age of 77. Dr. Cooper was a 1934 graduate of the University of Illinois College of Medicine, Chicago.

Dale, Thomas D., Hines, died March 8, 1985 at the age of 63. Dr. Dale was a 1955 graduate of Northwestern University Medical School, Chicago.

****Fahrner, Arthur H.,** Plainfield, died March 15, 1985 at the age of 92. Dr. Fahrner was a 1916 graduate of the St. Louis University School of Medicine.

***Giannini, Peter J.,** Oak Park, died March 22, 1985 at the age of 64. Dr. Giannini was a 1948 graduate of the University of Health Sciences/Chicago Medical School.

****Hanson, Joseph K.,** Moline, died March 17, 1985 at the age of 89. Dr. Hanson was a 1926 graduate of Loyola University Stritch School of Medicine, Maywood.

****Jackson, Arthur,** Chicago, died March 19, 1985 at the age of 91. Dr. Jackson was a 1919 graduate of Fak der Universitat Wein, Austria.

***Kinney, Raphael K.,** Deerfield, died March 4, 1985 at the age of 73. Dr. Kinney was a 1937 graduate of the University of Chicago Pritzker School of Medicine.

Krainer, Kaethe Fischer, Chicago, died February 18, 1985 at the age of 83. Dr. Krainer was a graduate of the University of Vienna, Austria.

****Langdon, Roy M.,** Chicago, died March 18, 1985 at the age of 79. Dr. Langdon was a 1929 graduate of Rush Medical College, Chicago.

***Maley, W. Forrester,** Evanston, died March 31, 1985 at the age of 77. Dr. Maley was a 1935 graduate of the University of Illinois College of Medicine, Chicago.

***Spira, Samuel B.,** Chicago, died March 21, 1985 at the age of 72. Dr. Spira was a 1939 graduate of the University of Illinois College of Medicine, Chicago.

****Steinhoff, Carl F.,** Joliet, died March 6, 1985 at the age of 90. Dr. Steinhoff was a 1920 graduate of Northwestern University Medical School, Chicago.

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*

Statement on Interprofessional Relations with Doctors of Chiropractic

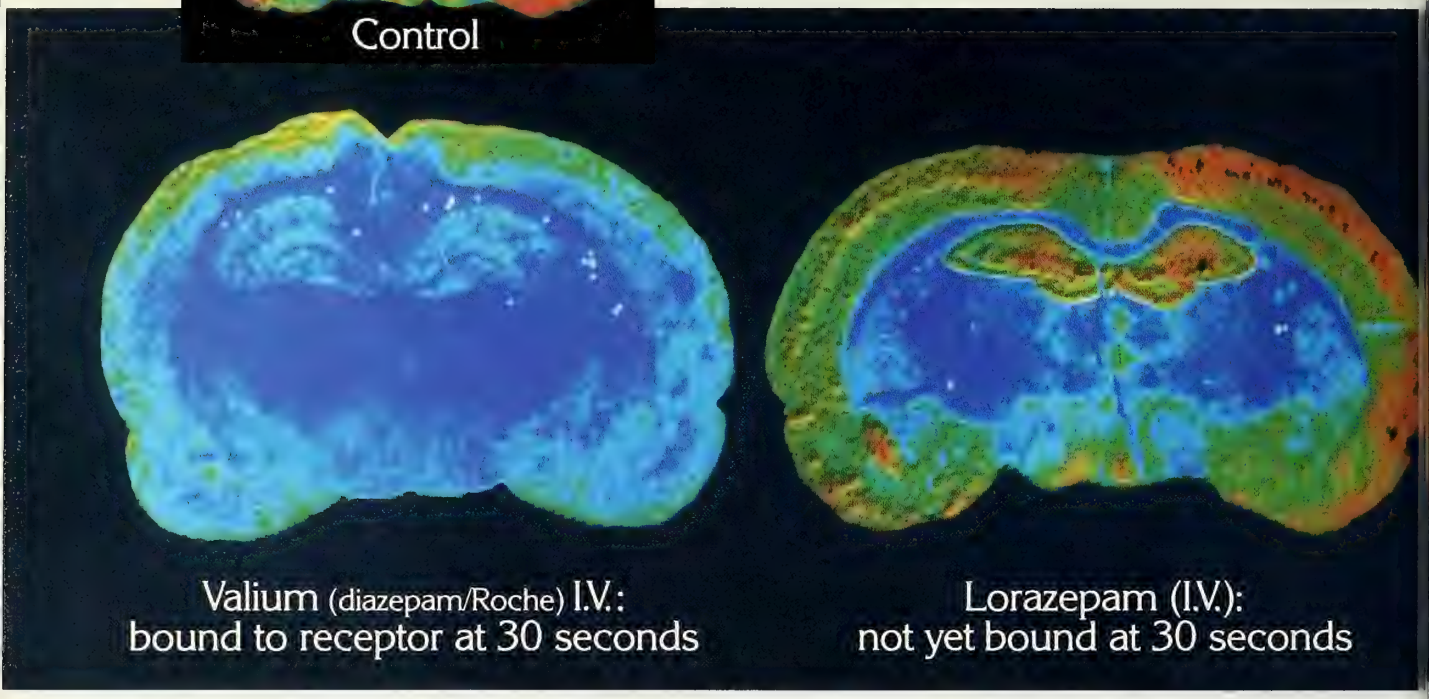
The Illinois State Medical Society declares that, except as provided by law (statute or final judicial opinion), there are and should be no ethical or collective impediments to full professional association and cooperation between doctors of chiropractic and medical physicians. Individual choice by a medical physician voluntarily to associate professionally or otherwise cooperate with a doctor of chiropractic should be governed only by legal restrictions, if any, and by the individual medical physician's personal judgment as to what is in the best interest of a patient or patients.

Professional association and cooperation, as referred to above, includes, but is not limited to, referrals, consultations, group practice in partnerships, HMO's, PPO's, and other alternative health care delivery systems; the provision of treatment privileges and diagnostic services (including radiological and other laboratory facilities) in or through hospital facilities; working with and cooperating with doctors of chiropractic in hospital settings where the hospital's governing board, acting in accordance with applicable law and that hospital's standards, elects to provide privileges or services to doctors of chiropractic; association and cooperation in hospital training programs for students in chiropractic colleges under suitable guidelines arrived at by the hospital and chiropractic college authorities; participation in student exchange programs between chiropractic and medical colleges; cooperation in research programs and the publication of research material in appropriate journals in accordance with established editorial policy of said journals; participation in health care seminars, health fairs or continuing education programs; and any other association or cooperation designed to foster better health care for patients of medical physicians, doctors of chiropractic, or both.

* * *

Animal studies demonstrated:

Valium (diazepam/Roche brain receptor sites duration than that



Receptor occupancy may be more relevant than plasma half-life in defining duration of action

The question under investigation:

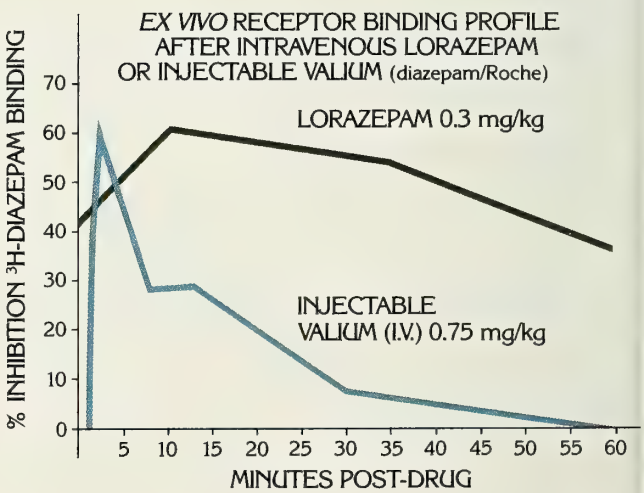
Why does lorazepam (I.V.), with its intermediate elimination half-life, evoke a longer period of amnesia and sedation than Valium (diazepam/Roche), which has a longer plasma half-life?

The postulate:

Lorazepam binds more tightly than diazepam to central benzodiazepine receptors—and remains bound longer.

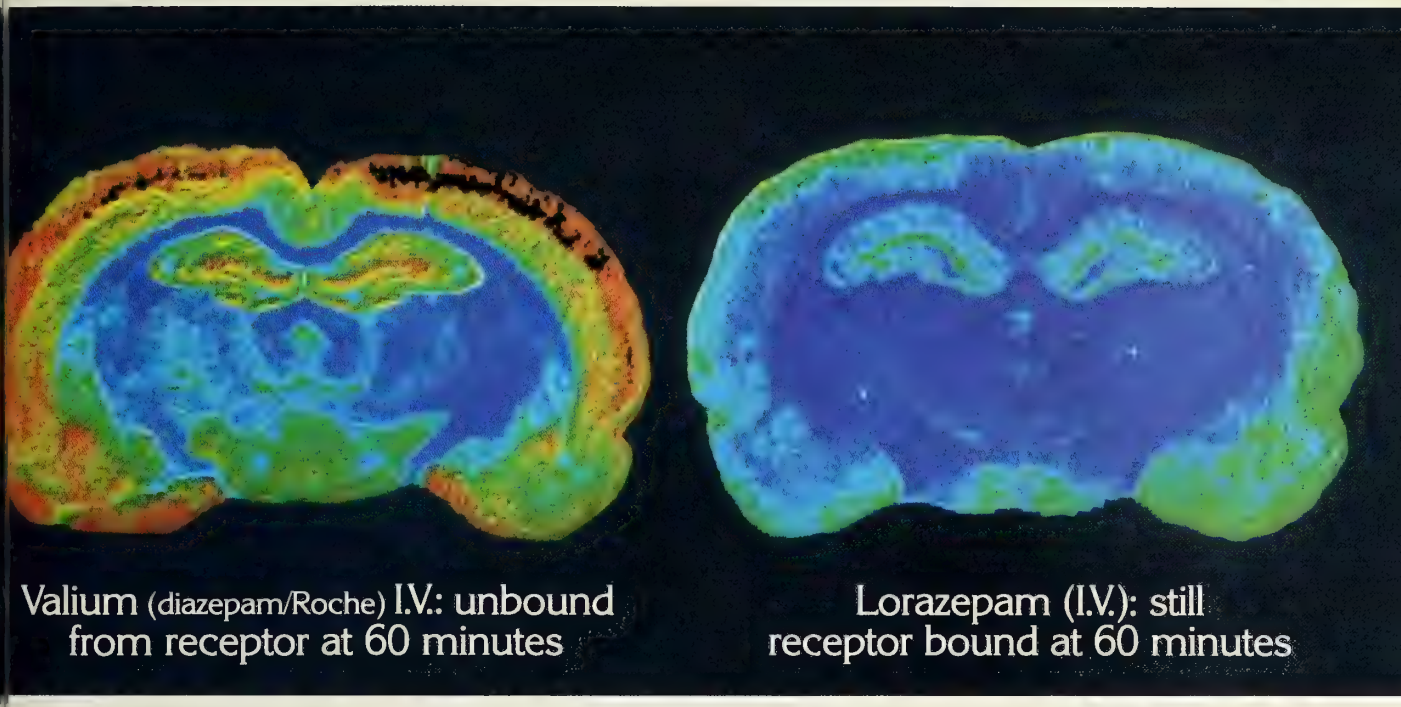
The experiments:

At varying times after dosing with I.V. diazepam or I.V. lorazepam, experimental rats were sacrificed and their brain tissues subjected to binding assays and autoradiography.



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occupancy of
was faster and of shorter
of lorazepam*



Valium (diazepam/Roche) I.V.: unbound from receptor at 60 minutes

Lorazepam (I.V.): still receptor bound at 60 minutes

The results:

Diazepam receptor occupancy peaked at 30 seconds after dosing and returned to baseline in 60 minutes. Peak lorazepam receptor occupancy did not occur until 10 minutes after dosing and continued to be strongly in evidence after 60 minutes, with 45% occupancy still being observed.

The exact nature of the correlation between benzodiazepine binding sites and receptors in relation to clinical effect is still being defined. Considerable evidence supports the correlation. Although these animal results are consistent with clinical experience concerning relative duration of action, direct human data on receptor binding and human effects are still under investigation.

VALIUM® IV
diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets
2-ml ready-to-use Tel-E-Ject® disposable syringes
2-ml ampuls, 10-ml vials } 5 mg/ml

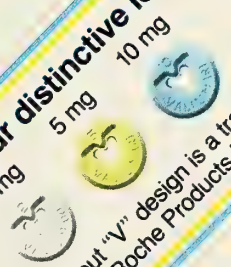
in the forefront of neuroreceptor research

*Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

ROCHE®

Please see next page for summary of product information.

Note our distinctive look



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Valrelease® (diazepam/Roche)℞ slow-release Capsules
Injectable Valium® (diazepam/Roche)℞

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome. *Oral forms* may be used adjunctively in convulsive disorders, but not as sole therapy. *Injectable form* may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion.

The effectiveness of diazepam in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets or capsules in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because their use is rarely a matter of urgency and because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins,* i.e., *dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Injectable Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least ¼, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, *i.e.,* phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed and tolerated).

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE: Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug. Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and after diazepam therapy are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia. In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Dosage: Individualize for maximum beneficial effect.

ORAL: *Adults:* Anxiety disorders, relief of symptoms of anxiety—Valium tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 Valrelease capsules (15 to 30 mg) daily. Acute alcohol withdrawal—tablets, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 capsules (30 mg) the first 24 hours, then 1 capsule (15 mg) daily as needed. Adjunctively in skeletal muscle spasm—tablets, 2 to 10 mg t.i.d. or q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. Adjunctively in convulsive disorders—tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. *Geriatric or debilitated patients:* Tablets—2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (see Precautions). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose. *Children:* Tablets—1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use in children under 6 months). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose (not for use in children under 6 months).

INJECTABLE: Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.)

For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., *dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcohol withdrawal, 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children *administer I.V. slowly;* for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary; in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly, repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary, keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension. Dialysis is of limited value.

How Supplied:

ORAL: Valium round, scored tablets with a cut out "V" design—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100 and 500; Prescription Paks of 50, available in trays of 10. Tel-E-Dose® packages of 100, available in boxes of 4 reverse-numbered cards of 25, and in boxes containing 10 strips of 10.

Valrelease slow-release capsules—15 mg (yellow and blue), bottles of 100; Prescription Paks of 30.

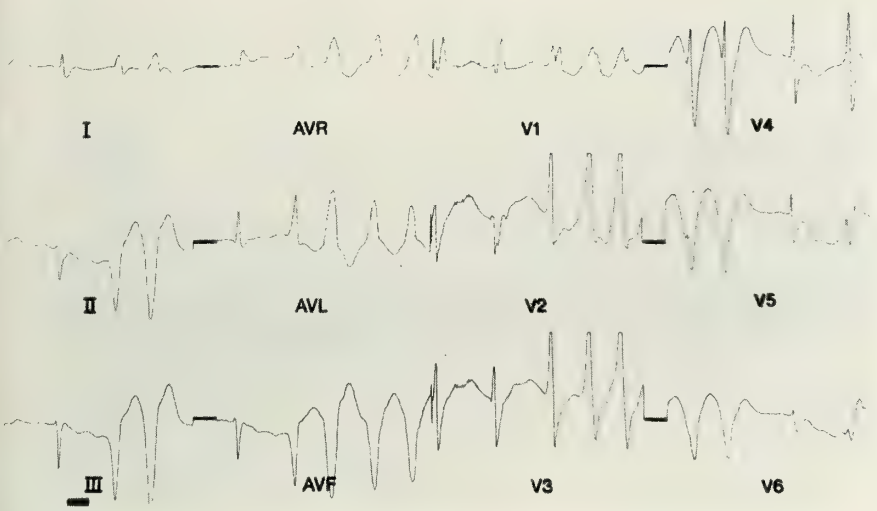
INJECTABLE: Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

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EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This patient is a 76-year-old man who was feeling well until two days ago when he suddenly developed lightheadedness. This disappeared as abruptly as it started. The lightheadedness recurred twice more and was severe enough to cause him to fall. There was no loss of consciousness and no seizure activity was seen by his family. There was a vague history of a myocardial infarction in the past and some cardiac arrhythmias. The patient was taking quinidine at the time of admission to the emergency service. The physical exam showed a blood pressure of 160/80mmHg without orthostatic hypotension. There were no carotid bruits and the lungs were normal. An atrial gallop was present on the examination of the heart. The cardiac rhythm was irregular. His blood count was normal and an arterial blood gas analysis was also normal. A chest x-ray showed a normal heart size and clear lung fields. This twelve lead ECG was obtained.



Questions:

1. **The twelve lead ECG shows:**
 a. Intermittent bundle branch block.
 b. Complete right bundle branch block.
 c. Left axis deviation.
 d. Bursts of atrial fibrillation.
 e. Bursts of ventricular tachycardia.

2. **Treatment of this patient could include:**
 a. A permanent ventricular demand pacemaker.
 b. Quinidine blood levels.
 c. Coronary care unit monitoring.
 d. Digoxin and diuretic medication.
 e. A bolus of intravenous lidocaine followed by an infusion of lidocaine.

(Continued on page 395)

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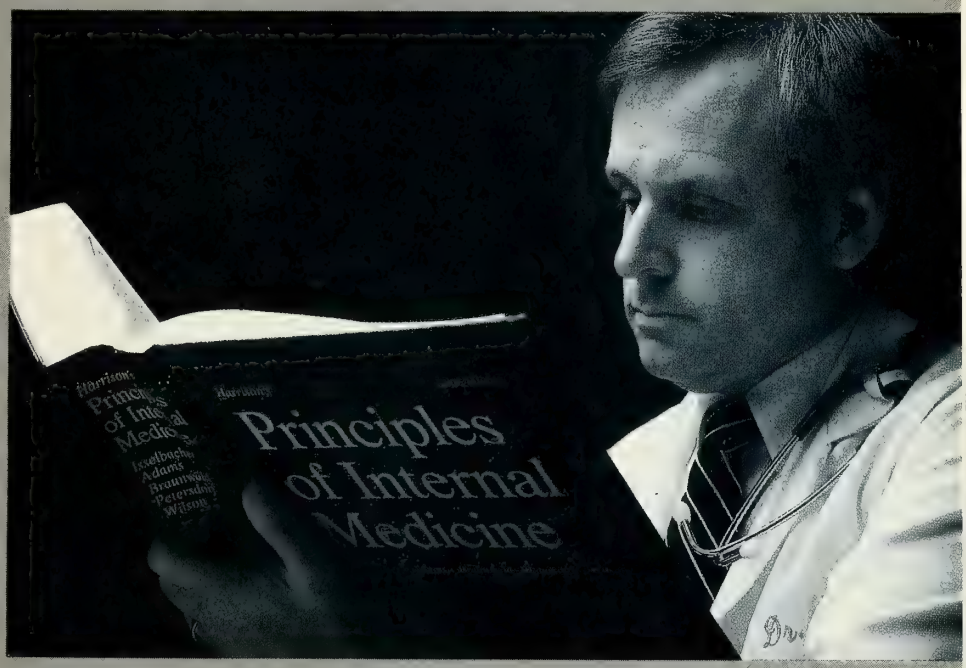
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Approved by the ISMS Board of Trustees, November 9, 1984

Approved by the ISBA Board of Governors, September 22, 1984

Guidelines on Attorney and Physician Relationships

Preamble:

Acknowledging that a significant part of the practice of law and medicine is concerned with the problems of persons who are in need of the combined services of an attorney, physician, and hospital; and that the public interest and individual problems in these circumstances are best served only as a result of standardized cooperative efforts of all concerned; we do adopt and recommend the following declaration of principles as guidelines of proper conduct for attorneys, physicians, and others concerned, subject always to the rules of law and guidelines of legal and medical ethics prescribed for their individual professional conduct.

A. With Respect to Attorneys and Physicians, Generally:

1. It should be recognized that potential areas of disagreement may arise between physicians and attorneys. Therefore, the nature and extent of services and fees, if any be charged, should be agreed upon in advance. If either party deems it desirable, such agreement should be reduced to writing.

2. The physician and the attorney should look for and discuss ways of minimizing the burden of medical-legal services on the physician and the costs thereof to the patient. It should be recognized that direct communication between the physician and attorney is preferable to communication between secretaries and receptionists.

3. Whenever an attorney and a physician are unable to agree in advance on the cost of medical-legal services, the two professionals should:

 (a) continue to act in the best interest of the patient-client;

 (b) define the agreement as narrowly as possible, agreeing on as much as possible;

 (c) refrain from unprofessional remarks or conduct and avoid personal comments.

B. With Respect to Attorneys, Generally:

1. An attorney intending to call or subpoena a physician to testify in court or by deposition should notify the physician as far in advance as possible. He should also call the physician after a trial has started to give the physician as much advance notice as possible. Further, the attorney should withdraw a witness from the witness stand and put the physician on, out of turn, whenever possible.

2. An attorney intending to call or subpoena a physician to testify by deposition should, if possible, attempt to schedule the deposition at a time and place convenient to both the attorney and the physician.

3. An attorney seeking only a physician's records should, after consultation with the physician, subpoena a custodian of those records rather than the physician, whenever possible.

4. An attorney intending to call a physician to testify as an expert witness should recognize that the physician has a right to be compensated for such expert testimony regardless of the outcome of the case.

5. An attorney should arrange a pre-testimonial conference with the physician to review his testimony with him and to review the standard procedures of cross-examination.

6. An attorney and a physician should agree in advance as to the amount of compensation owed to the physician for pre-testimonial conferences, testifying or preparing a report. A physician may ask for all or any portion of such fee in advance.

7. Attorneys should refrain from giving advice to clients on medical treatment.

8. Unless otherwise requested, an attorney requesting a medical report from a physician is asking for a report which follows the "Guidelines for Medical-Legal Reports," attached as Appendix A hereto.

9. An attorney should inform his client of the obligation to pay his physician for professional services rendered as soon as possible, regardless of the status of the lawsuit and, absent legally valid circumstances to the contrary, should not advise his client that it is proper to withhold payment until the lawsuit is disposed of.

10. A statutory lien exists to ensure payment of a physician's fees, which lien can be served on the plaintiff's attorney and/or defendant's attorney or defendant's insurance company. The physician's office should notify the plaintiff's attorney of any satisfaction of the lien. If there is no recovery, the attorney should remind the client-patient of his obligation to pay the physician.

11. An attorney should, as a matter of courtesy and information, notify any physician whose services he has retained as a medical expert, of the outcome of the litigation.

C. With Respect to Physicians, Generally:

1. It is recognized that the duty of the physician includes not only the treatment of the physical and mental difficulties of the patient, but also making available for the benefit of the patient, the facts of his situation to the end that justice may be served. Accordingly, the physician, when properly requested by the patient either directly or through his attorney, shall provide reports, appear in court or attend depositions and testify with full, fair and candid answers to the questions propounded to him concerning such facts and his opinions relative thereto.

2. Although a physician has a right to request that his testimony be taken by way of deposition, he must recognize that the law may require his presence in court and that his patient's best interests may be served by his presence in court.

To the Members:

The Illinois State Bar Association's Standing Committee on Interprofessional Cooperation and the Illinois State Medical Society's Medical Legal Council have worked jointly over the past several years to establish the following "Guidelines on Attorney and Physician Relationships." The "Guidelines" have received the approval of the respective governing boards and are being jointly published this month in both associations' journals.

The "Guidelines" are advisory in nature, but will hopefully serve as a model for local bar associations and medical societies to further interprofessional cooperation in general and for individual attorneys and physicians to assist each other in better serving clients and patients. For, indeed, whatever other differences may exist between the professions, it is the obligation to our patients and clients that must be our paramount concern.

Morgan M. Meyer, M.D.
President
Illinois State Medical Society

Jon W. DeMoss
President
Illinois State Bar Association

3. A physician who has been called to testify by deposition should attempt to schedule the same at a time and place convenient to both the attorney and the physician.

4. A physician is entitled to fair and reasonable compensation for medical-legal services, but the same shall not be conditioned upon nor measured by the amount of the patient's recovery in damages in the litigation. Physicians should be aware that an attorney who requests their medical-legal services does so on behalf of his client. The Illinois courts have held that, absent a specific agreement otherwise, an attorney is not personally liable for the physician's charges and that the responsibility for payment of physician's charges lies solely with the client. If the physician is not in a position to judge the ability of the client to pay for services, the attorney may be asked to either provide payment in advance or personally guarantee payment of the physician's bill for medical-legal services.

 Charges for medical-legal services should be no higher than a physician's charges for other medical services, and shall be computed having due regard for the time, effort and skill consumed. Such fees shall neither be so high as to have the effect of preventing the patient from obtaining the physi-

Appendix A

Guidelines for Medical-Legal Reports

Guidelines are proposed for the preparation of a medical-legal report. It is suggested that the report include the following:

1. Date of initial examination.
2. Medical history to the extent known.
3. History of injury and resultant symptoms. The physician should give a short report of essential facts as related by the patient.
4. Detailed physical examination and description of findings. The objective tests performed, the results of the tests, and any unusual observations from examination. The specific parts of the body should be mentioned in which symptoms were observed.
5. Symptoms (subjective)—when there is no positive evidence that the patient is malingering, he should be given the benefit of the doubt. Physicians should record small details which may have a vital bearing on later serious complications. For example, brief unconsciousness and minor hematoma on the head may be precursors to traumatic epilepsy. Symptoms not existing before the accident should be included in the report, as should significant negative findings. Nervousness and shock should be noted. The elucidation and recording of all subjective symptoms aids not only the patient, but also the establishment of a diagnosis.
6. Results of diagnostic studies—the results of all tests (including x-ray) should be given as well as the names of the physicians, technicians or laboratories making the tests.
7. Diagnosis—a complete but concise diagnosis should be given stating reasons. Minor symptoms should not be overlooked. If there is no definite evidence of malingering and the symptoms are medically acceptable, the patient should be given the benefit of the doubt.
8. Treatment—all treatment should be described exactly as given. This statement includes treatment at the scene, in the office, in the home, or at the hospital. The date, symptoms, findings and treatment performed or prescribed at each visit should be indicated. The name of the hospital or other health care facility should be recorded along with the length of time of treatment or institutionalization. The name of any other provider of care should also be noted, along with the nature and length of the treatment.
9. Response to and compliance with treatment.
10. Prognosis—a prognostic statement records medical opinion as to possible future suffering or consequences arising from the injury, disease or course of treatment. It should include such items as future pain and suffering, future required medical treatment, expected partial or permanent disability, life expectancy and expected period of recovery. It should be recognized that a medical prognosis is an essential part of the medical report and will be used to establish the damages.

The report to the attorney should be objective, impartial and complete. The examining physician should not give, and should not be asked to give, a report that does not comply with these standards.

cian's medical-legal services, nor so high as to give the appearance that the physician is attempting to capitalize on the patient's legal problem.

A physician who has not been paid for treatment rendered by him to his patient should still cooperate fully with the attorney for his patient. He should not refuse nor slow down the submission of medical records or reports, participation in conferences with the attorneys, testimony at depositions or trial, or any other actions necessary to the resolution of the patient's legal claim. Similarly, he should not vary the fees he normally charges for these services.

5. Physicians should refrain from giving patients advice on legal matters or expressing opinions on legal matters to patients.
6. A physician, on testifying in court, should not decide legal questions by determining that certain questions are improper and either refusing to answer or treating the question as if it were unimportant or insignificant and therefore answering only in part. If a physician feels that a question is improper and if there is no objection to the question from any attorney, the physician may ask the Court whether he is bound to answer such question.
7. Where a report is requested, the physician should insist upon written authorization from a patient before providing the requested information or report. When a medical report is properly authorized, the physician should furnish the report.

 (a) Where there is no dispute over the amount to be charged by the physician for the report, the physician may refuse to provide the report where the amount is not paid in advance.

 (b) Where the amount to be charged by the physician for the report is in dispute, the physician shall furnish the report after being paid the amount not in dispute, pending resolution of the dispute.

8. Unless otherwise agreed upon in advance, a standard or normal report should follow the "Guidelines for Medical-Legal Reports," attached as Appendix A hereto. Such a report shall command a standard, reasonable fee.

D. With Respect to Special Situations, Generally:

1. A physician receiving a communication from an attorney advising that the attorney is investigating the possibility of bringing or maintaining a medical malpractice suit on behalf of the physician's patient or former patient (accompanied by proper authorization) has a general obligation to honor the authorization and provide the attorney with access to or copies of his patient records and, if illegible, a legible and literal transcription of the same into legible form. The physician has a right to request in advance reasonable payment for such records or transcripts. The personal notes of therapists pursuant to Ill. Rev. Stat., Ch. 91½, ¶803, are, however, privileged by law against disclosure.

2. Subject to the attorney-client privilege, when an attorney involved in a malpractice suit refers his client to a specific physician for examination, the attorney should notify that physician of any ongoing malpractice claims. A physician not so notified may refuse to provide a report to that attorney.

E. Standing Joint Medical-Legal Committee:

A standing statewide Joint Medical-Legal Committee shall be designated to address questions of physicians and attorneys relative to interprofessional problems. The formation of local and regional medical-legal committees is encouraged to deal with specific interprofessional problems.

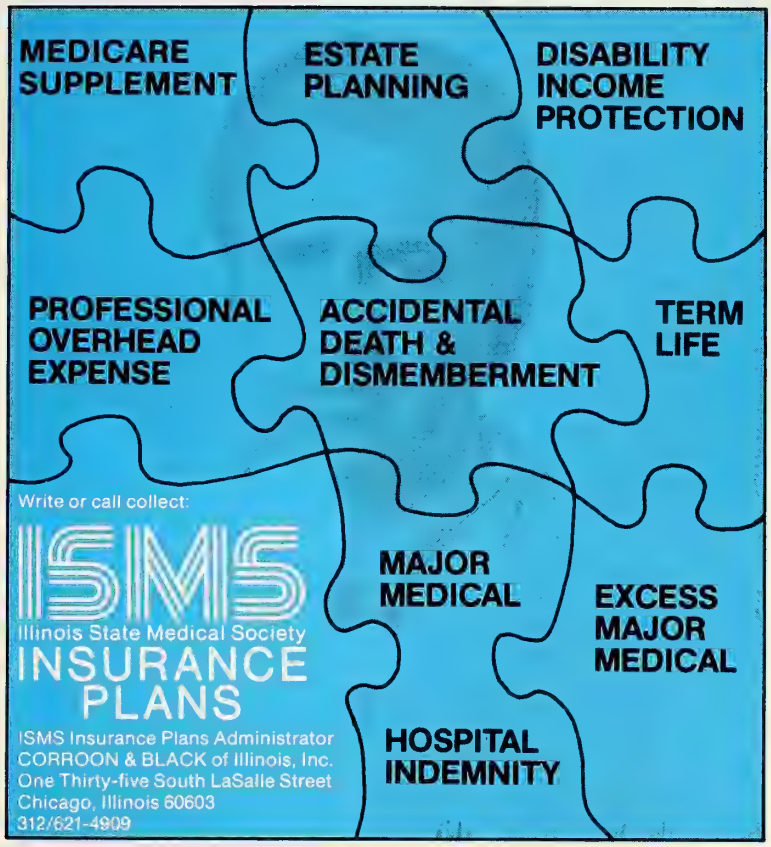
The Guidelines on Attorney and Physician Relationships should be publicized in the regular publication of each organization and copies be distributed to members of both professions.

SOLVE YOUR PROTECTION PUZZLE

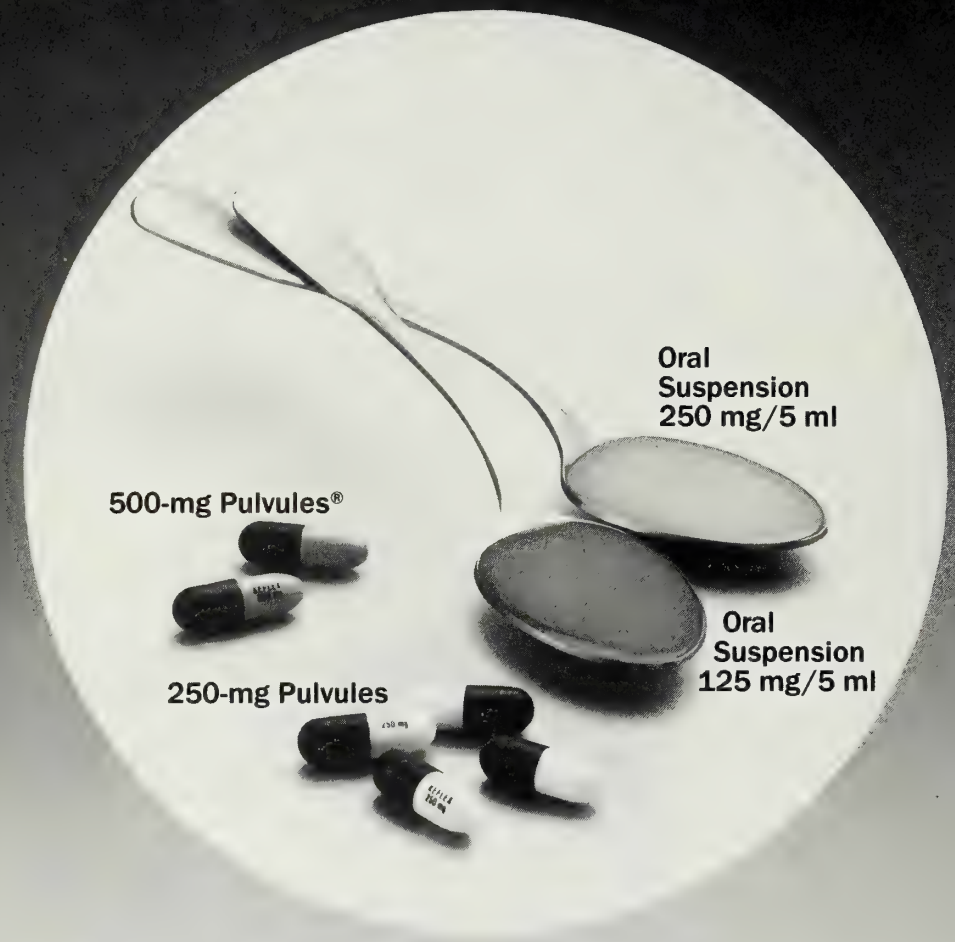
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Anxiety Relief for the Patient Who Must Remain Alert[1-8]



Tranxene dramatically increased beta wave activity

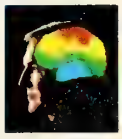
- relieved anxiety
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In a double-blind randomized study of 20 patients with generalized anxiety disorder, patients treated with Tranxene showed marked improvement in Hamilton Anxiety Ratings, and dramatic increase in beta wave activity. Increased beta wave activity was correlated with improvement on the intellectual item (difficulty in concentration, poor memory) of the Hamilton Anxiety Rating Scale.[1]

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Brief Summary of Prescribing Information

INDICATIONS—For management of anxiety disorders or short-term relief of symptoms of anxiety; for symptomatic relief of acute alcohol withdrawal; for adjunctive therapy in partial seizures.

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CONTRAINDICATIONS—Known hypersensitivity to the drug. Acute narrow angle glaucoma

WARNINGS—Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

Pregnancy and Lactation: Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers

PRECAUTIONS—Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

ADVERSE REACTIONS—Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure

INTERACTIONS—Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

OVERDOSAGE—Take general measures as for any CNS depressant

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Impact on Gynecologic Oncology Procedures

CO_2 Laser Surgery

By Josh C. Tunca, M.D./Chicago

CO_2 laser treatments of female lower genital premalignant and benign lesions are now established procedures, and no longer regarded as experimental. The laser beam can be directed mechanically through the colposcope (an operating microscope) for micro-precision surgery without harming the vicinity tissues and organs. Laser surgery has converted high-risk, costly inpatient procedures to quick, less-costly, and low risk outpatient procedures. The specifics of the laser treatment of benign and premalignant gynecologic lesions are discussed in the text.

With the increase of sexual freedom and multiple partners, intraepithelial neoplasias of the female lower genital tract have become more common in younger women, and incidence is on the rise. Intraepithelial lesions of the lower genital tract may occur concurrently, which suggests a common agent transmitted through intercourse.

Better understanding of the pathology and physiology of preinvasive lower genital tract lesions has resulted in more conservative trends in the treatment of these lesions and enhanced emphasis on preservation of the functional and anatomical integrity of the female genital organs.

The increased incidence of premalignant lesions in the female lower genital tract is possibly related to the increasing prevalence of condyloma caused by human papilloma virus infections.[1,2] Diagnosis of these lesions includes the use of the colposcope to locate and recognize the lesions, and biopsies for histologic verification.

The CO_2 laser was first used for gynecology in 1973.[3] Laser treatments of gynecologic diseases are now established procedures, and no longer considered experimental. CO_2 laser technology brought about a revolution, especially in the treatment of premalignant female genital tract lesions and condylomas. The laser beam can be directed mechanically through the colposcope for precision surgery. A gynecologic laser surgeon can vaporize or excise abnormal tissues to any depth or width in micro-precision without harming the local tissues and organs.

Evolution of CO_2 Lasers

In 1917, Albert Einstein postulated that light could be produced by stimulating atoms with external energy.[4] In 1960, Dr. T. Maiman created the first Light Amplification by Stimulated Emission of Radiation (LASER) from synthetic ruby crystals. The first laser energy lasted only several hundred microseconds, but it stimulated revolutionary concepts and devices in the treatment of many diseases.

In 1960, Dr. Patel developed the CO_2 laser. The CO_2 laser's wavelength is 10.6 microns. Its energy is absorbed by water, and causes instantaneous vaporization and incineration of tissues to elemental carbon and fumes. The CO_2 laser beam is in the invisible neo-infrared energy spectrum. For this reason, together with the CO_2 laser beam, a visible helium-neon laser beam is used as a pathfinder.

Instrumentation

Today the CO_2 laser is one of the most powerful lasers existing in the medical field. Wattage may extend from 25 to 100 watts. Instruments with superpulses to 500 watts are available. The laser beam is mainly delivered through a colposcope and is manipulated by a control stick. The surgeon can use the laser beam as a scalpel or tissue vaporizer by increasing or decreasing the wattage, and can also control the duration of tissue exposure to the laser beam.

A special filtered smoke evacuation system has to be used during the laser surgery. Otherwise, ordinary operation room suction tubes will be clogged with carbon and fumes.

Application of the CO_2 Laser in Gynecologic Oncology

In order to use laser surgery in gynecologic oncology, the gynecol-

ECTOCERVICAL DISEASE



8-10mm

VAPORIZED
DOME-SHAPED DEFECT

Figure 1

ENDOCERVICAL DISEASE



1·5-1·8cm

EXCISED
CYLINDRICAL DEFECT

Figure 2

ENDOCERVICAL AND ECTOCERVICAL DISEASE



1·0-1·5cm

EXCISION
AND
VAPORIZATION

Figure 3

ogist has to be an accomplished and experienced colposcopist. The colposcope helps the surgeon localize the premalignant and malignant lesions of the female genital tract.

Cervical Application

The CO_2 laser is mainly used in the treatment of cervical intraepithelial neoplasia. Three types of laser surgery techniques are applied, depending on the locality of the abnormal transformation zone (abnormal metaplasia occurring zone) and squamo-columnar junctions.

The abnormal transformation zone is completely observed, including the squamo-columnar junction, through the colposcope. A dome-shaped vaporization of the ectocervical lesion is accomplished by the laser beam to a depth of 8-10mm, to the stroma of the cervix. In this way, all the diseased tissue can be eradicated (Figure 1).

The abnormal transformation zone is completely retracted to the endocervical canal, and the squamo-columnar junction is not observed colposcopically. The laser beam is used as a scalpel, and a cylinder-shaped specimen is removed from the cervix, 6mm in width and 1.8 to 2cm in depth. In this way, the entire diseased endocervical canal is removed. The whole process takes eight minutes with less than a 25ml blood loss (Figure 2).

The abnormal transformation zone is retracted partially to the endocervical canal, and the squamo-columnar junction is partially observed. A shallow laser cylinder excision with peripheral laser vaporization of the ectocervix is accomplished (Figure 3).

These three procedures remove the entire transformation zone. Tissue heals very rapidly and defects fill very quickly. Only in laser surgery, not in cold knife biopsy or cryosurgery, does the transformation zone come back to the cervical os after healing. This enables the gynecologist to follow the patient easily with the colposcope and cervical cytology.

Cervical tissue heals rapidly (in 21 days) after laser surgery and develops no scar tissue, stenosis, cervical incompetence, or distortion. Wright[5] reports a 95.3% success rate for the entire patient population with laser surgery. The cryosurgery failure rate is approximately 18% at the first treatment. Also, after cryosurgery, usually the transformation zone and squamo-columnar junction retracts to the endocervical canal, and the follow-up of these patients becomes fairly difficult.

Vulvar Application

In the majority of cases, laser surgery has already replaced the simple vulvectomy or wide local excisions and grafts for vulvar intra-epithelial neoplasias (VIN). After laser surgery, the vulvar skin heals rapidly without any scar tissue. The clitoris is preserved, and the vulva is not destroyed either functionally or cosmetically.

For condyloma of the vulva, laser surgery has completely replaced podophyllin application, cryosurgery and shaving. Post-laser surgery healing is excellent. During the procedure, the exocervix is flushed with the laser beam to destroy the virus-harboring tissues. Also, the entire vulva, vagina, and cervix are visualized colposcopically for condylomas that are not observed with the naked eye.

Application for Vaginal Surgery, Anal Condylomas and Intraepithelial Neoplasias

Vaginal laser surgery has replaced vaginectomies for vaginal intraepithelial neoplasias (VAIN). It is quick, effective, and causes almost no blood loss. Healing is excellent, without any scarring, and functional anatomy is preserved completely.

Laser surgery gives excellent results, and causes no scar tissue.

Again, healing is very rapid. It has already replaced previous invasive operations.

Anesthesia

Laser procedures are done in the outpatient area. The majority of cervical cases are done without anesthesia or under paracervical blocks. Vulvar cases usually are done under general anesthesia. As soon as the patients recover from the general anesthesia, they are discharged. Usually, peri- and post-laser surgery discomforts are minimal and extremely well-tolerated by the patients.

Safety Precautions

The eyes are protected with plastic goggles. Explosive gases or vapors, and flammable solutions should be kept away from the laser operation room. The gynecologic laser surgeon needs a thorough knowledge of colpsocopy, laser physics and laser instruments, as well as good eye-hand coordination. Only laser surgeons that satisfy hospital laser safety committee requirements should be permitted to practice laser surgery.

The Future

Laser surgery has revolutionized many procedures, not only in gynecology, but also in urology, neurosurgery, pulmonary medicine, and gastroenterology. It also has converted high-risk and costly inpatient procedures to quick and less costly, low risk outpatient procedures. In the future, not only the patients, but also the hospitals, general public, and the government will benefit from the multi-disciplined laser surgeries. ◀

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Photographs courtesy of Dr. Cecil Wright.

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Diagnostic Significance

Creatine Kinase Isoenzymes

BY MICHAEL A. PESCE, PH.D./NEW YORK, NEW YORK

Fractionation of CK isoenzymes is requested to rule out or confirm the diagnosis of acute myocardial infarction because serum CK-MB levels are elevated when there is damage to the myocardium. In addition to CK-MB and CK-BB, atypical CK isoenzymes can also be detected in serum. Although these CK isoenzymes may not have any clinical significance, they will cause false positive CK-MB results with some assays that are used for measuring CK-MB.

Creatine kinase (CK) (EC 2.7.3.2. ATP: creatine N-phosphotransferase) catalyzes the reversible phosphorylation of creatine by the following scheme: Creatine + ATP ⇄ creatine phosphate + ADP.

Creatine phosphate is found in the myofibrilis and mitochondria of the muscle cell and represents a potential source of reserve cellular energy for contraction, relaxation and transport of substances within the muscle cells. Adenosine triphosphate (ATP) is the primary energy source. During periods of prolonged work, when enough ATP cannot be generated by oxidative phosphorylation, ATP is formed from creatine phosphate. CK is a key enzyme in the energy metabolism of muscle cells.

CK is a dimer consisting of M and B subunits which combine to form three isoenzymes: CK-MM, CK-MB and CK-BB, which can be separated electrophoretically using either agarose gel or cellulose acetate mediums. CK-BB migrates the farthest toward the anode; CK-MM remains essentially at the point of application and CK-MB migrates between CK-MM and CK-BB. Recently, atypical CK isoenzymes migrating either between CK-MM and CK-MB or cathodic to CK-MM were detected in serum.

In this report, the diagnostic implications of the CK isoenzymes, as well as the effect of CK-BB and the atypical CK isoenzymes on the CK-MB results will be presented.

CK-MB

Although CK-MM is the predominant CK isoenzyme in heart and skeletal muscle, CK-MB is present in the heart muscle in amounts ranging from 20 to 40% of the total CK activity. CK-MB is also found in skeletal muscle. Type 2 skeletal muscle or red fibers, such as the soleus and intercostal muscles, contain CK-MB in amounts up to 10% of the total CK activity. Type 1 or white fibers, such as the gastrocnemius, contain CK-MB at about 1% of the total CK activity.

CK-MB is either absent or present in small quantities in the serum of normal adults. However, considerable amounts of CK-MB were detected in serum of normal neonates and children.[1-3] The reference values for CK-MB can be expressed as the activity of CK-MB in u/L, the percent of CK-MB activity, or in mass concentration units, ug/L. The latter technique is usually not used in most clinical laboratories. The main advantage in expressing the CK-MB results as percent of CK-MB activity rather than in absolute CK-MB activities is to differentiate massive skeletal muscle damage from myocardial injury. A CK-MB value of greater than 5% of the total CK activity is usually considered abnormal. However, each laboratory should establish their own reference values.

After injury to the myocardium, the cytoplasmic CK isoenzymes, CK-MM and CK-MB, are released into the peripheral blood. Therefore, elevated serum CK-MB values are used as sensitive and specific indicators of acute myocardial infarction (AMI). In uncomplicated cases of AMI, total CK and CK-MB activities are elevated. CK-MB levels increase 4-8 hours after the infarct, reach a maximum level at 12-24 hours and then decline to baseline values, usually within 48 hours. Total CK activities increase 4 hours after the infarct, reach a maximum value at 24 hours and then slowly decline to baseline levels at about

72 hours. CK-MB activity decreases faster than total CK activity because the half life of CK-MB is shorter than CK-MM. In cases of reinfarction, a substantial increase in total CK and in CK-MB values will be observed. However, the time sequence for collection of blood is crucial for an accurate diagnosis. Normal CK-MB activities may be obtained in patients with AMI because blood was collected too soon after the infarction, or the patient was admitted to the hospital several days after the episode. In the latter case, the lactate dehydrogenase (LDH) isoenzymes should be monitored in order to determine if there is a substantial increase in the activity of LDH 1 or if the LDH 1/LDH 2 ratio is elevated.

A common protocol for CK-MB analysis in cases of suspected AMI is collection of blood on admission or after the onset of chest pain, and thereafter at 12 hour intervals for up to 48 hours.[4] In uncomplicated cases of AMI, CK-MB values in blood collected after 48 hours are not clinically useful.

In patients with AMI, the total CK activity is usually elevated. However, there are reports of proven AMI in patients with normal total CK activities but with elevated CK-MB levels (expressed as percent of total CK activity).[5] This usually occurs in elderly patients with very low baseline levels of CK. After an AMI, there is a substantial increase in the total CK activity, but not above the upper limit of normal. If the CK-MB results were expressed as units of activity of CK-MB rather than as percent of total CK activity, low CK-MB values would be obtained. In order to eliminate possible misinterpretation of the biochemical data, it is important to express the CK-MB results as percent of total CK activity.

Table 1 lists conditions other than AMI in which CK-MB can be detected in serum. The most frequent causes of elevated CK-MB levels are after cardiac surgery, especially aortocoronary bypass surgery and in muscular disorders. The source of the CK-MB after coronary artery bypass surgery is probably due to manipulation of the heart muscle. After coronary artery bypass surgery, it is difficult to determine if the myocardial injury is due to surgical trauma or myocardial infarction.[6]

Table 1
Abnormalities Other Than AMI Resulting In Serum CK-MB Activities

CARDIAC DISORDERS
Angina pectoris
Atrial fibrillation
Congestive heart failure
Coronary bypass surgery
Myocarditis
SKELETAL MUSCLE DISORDERS
Duchenne muscular dystrophy
Dermatomyositis
Viralmyositis
Polymyositis
Rhabdomyolysis
OTHERS
Strenuous exercise
Cesarean section
Lung cancer
Rhabdomyosarcoma
Acute pancreatitis
Gastrointestinal resection
Alcoholic intoxication
Prostate resection
Malignant hyperthermia
Hypothyroidism
Hyperthermia
Reye's syndrome
Septicemia
Rocky Mountain spotted fever
Acromegaly

CK-MB levels in serum are usually elevated in muscular dystrophies,[7] dermatomyositis and polymyositis.[8] The level of CK-MB in the serum of these patients remains fairly constant and is believed to originate from skeletal muscle. The differential diagnosis of AMI in these patients may not present a problem if: (a) the baseline CK-MB values are known and (b) if CK-MB levels are monitored after the onset of chest pain, in order to determine if the CK-MB values peak and then decline to baseline levels.

Extremely elevated CK-MB and CK-BB levels were obtained in two patients whose diagnoses were: lung cancer[9] and rhabdomyosarcoma.[10] The source of CK-MB in patients with carcinomas was believed to be from the tumor. However, since these patients had high CK-BB levels, CK-MB could originate from a hybridization reaction between CK-MM and CK-BB.

In athletes, (marathon runners[11] and swimmers[12]) the baseline CK-MB levels can approach the upper limits of normal and may increase to elevated values after a competitive event. Therefore, the differential diagnosis of AMI in individuals undergoing vigorous physical exercise is difficult.

There are many disorders in which small quantities of serum CK-MB have been detected. In myocarditis, angina and congestive heart failure, usually trace, but sometimes elevated CK-MB levels are found.[13-15] CK-MB may originate from the myocardium due to transient ischemia which can result in changes in membrane permeability permitting leakage of cytoplasmic CK isoenzymes. CK-MB has been found in trace amounts after prostate resection, cesarean section and gastrointestinal section.[16] CK-MB is also found in Reye's syndrome[17] due to damage to the myocardium and in acute alcoholic intoxication[18] due to skeletal muscle damage. In hypothermia and malignant hyperthermia, CK-MB can originate from both the heart and skeletal muscles.

Although CK-MB can be detected in serum in a wide variety of disorders, it does not compromise its clinical usefulness in AMI because in many of the clinical conditions listed in Table 1, trace amounts of serum CK-MB were found. In AMI, CK-MB levels are elevated and after the onset of chest pain, increase to a peak value followed by a decline to baseline levels. However, the diagnosis of AMI cannot be based only on biochemical data. The patient's medical history, electrocardiogram and the biochemical results must all be considered before making a diagnosis of AMI.

CK-BB

CK-BB is usually not detected in the serum of normal adults, but is usually present in newborns and may be found in children up to the age of four years.[1,2] CK-BB is the major CK isoenzyme in the thyroid,

Table 2
Abnormalities Associated with Serum CK-BB Activities

Carcinomas of prostate, breast, gastric, oatcell of the lung, stomach, rectal, colon, testis, gallbladder
Cerebrovascular accidents
Craniotomy
Anoxia caused by hypothermia, cardiopulmonary arrest, congestive heart failure
Spinocerebellar atrophy
Werdnig-Hoffman disease
Acute and chronic renal disease
Hemodialysis
Renal transplant
Prostate resection
Cesarean section
Coronary arterial bypass surgery
Acute myocardial infarction
Reye's syndrome
Malignant hyperthermia
Bowel resection
Ruptured abdominal aneurysm
Hypothermia
Acute pancreatitis

lung, kidney, prostate, spleen, liver and pancreas. However, the total CK activity in these organs ranges from 1/40 to 1/500 that of skeletal muscle and, therefore, injury to these tissues would result in small or undetectable amounts of CK-BB in serum. The organs with the highest CK-BB activity are the brain, bladder, gastrointestinal tract, placenta and uterus and contain approximately 1/10 of the total CK activity found in skeletal muscle. Therefore, damage to these tissues can result in measurable amounts of CK-BB in serum.

Table 2 lists some of the clinical conditions associated with CK-BB levels. CK-BB was detected most often in central nervous system disorders, renal disease, damage to a pregnant uterus, aortocoronary bypass surgery and carcinomas. In central nervous system disorders, CK-BB was detected in serum only when there was breakdown of the blood-brain barrier.[19] CK-BB was found in the serum of amateur boxers 10 to 30 minutes after the fight. The source of CK-BB was probably the brain because the level of CK-BB could be related to the number of blows to the head received by the boxer.[20]

Substantial amounts of CK-BB were detected in patients experiencing chronic renal failure, hemodialysis and renal transplants.[21] In many of these specimens, there was a band which migrated and fluoresced close to the CK-BB fraction and could be misinterpreted as CK-BB. However, if the electropherogram was placed under an ultraviolet lamp, a yellow elongated band that is clearly distinct from CK-BB would be observed. This artifact was assumed to be either ligands bound to albumin,[22] salicylate,[23] or pyridoxal-5-phosphate.[23]

CK-BB was found in serum of women during labor, after a normal delivery and after Cesarean sections.[16,24] The CK-BB activity in the enlarged uterus increases during pregnancy and CK-BB can be detected in serum after childbirth. Umbilical cord blood and the placenta contain substantial amounts of CK-BB and might be useful sources of CK-BB for quality control studies.[25]

In our laboratory, CK-BB was detected using agarose gel electrophoresis in 40 out of 2250 patient samples for an incidence of 1.8%. The majority of these patients had either coronary artery bypass surgery or carcinomas. In patients with bypass surgery and without complications of AMI, CK-BB was detected in amounts ranging from 3 to 6% of the total CK activity. The source of CK-BB was probably not from the myocardium but could be from the saphenous vein which contains CK-BB in amounts similar to that found in the brain.[26]

In patients with carcinomas, considerable amounts of CK-BB can be detected in serum. In our laboratory, CK-BB was measured in amounts ranging from 7 to 57% of the total CK activity in patients with carcinomas of the prostate and breast. CK-BB has been detected in many patients with prostate cancer[27] and has been proposed as a tumor marker for these patients. However, CK-BB is usually found in the latter stages of the disease and probably does not have any clinical relevance. The source of CK-BB in cancer patients could be either from the tumor, or its metastases.

Table 3
Clinical Diagnoses of Patients with the Anodic CK Isoenzyme

CARDIAC DISORDERS
Acute myocardial infarction
Atrial fibrillation
Mitral valve replacement
Angina pectoris
Ischemic heart disease
Congestive heart failure
Coronary artery bypass surgery
NON-CARDIAC DISORDERS
Bronchitis
Rheumatoid arthritis
Acute lower back pain
Upper respiratory tract infection
Non-specific chest pain
Temporal arteritis
Thyrotoxicosis
Prostate cancer
Gastric cancer with metastases to liver
Breast cancer
Psychoneurosis
Anxiety
Depression
Gastrointestinal spasms
Cholelithiasis
Ulcerative colitis
Healthy asymptomatic individuals

The duration of CK-BB in the serum in most of these disorders, listed in Table 2, is transient because: (1) CK-BB has a short biological half life of 1-5 hours; (2) CK-BB may be transformed in vivo to a form that migrates close to CK-MB; (3) the amount of CK-BB present in human organs is small and (4) CK-BB is unstable at 37°C. Most methods measure CK-BB by incubating serum at 37°C, which can result in deactivation of CK-BB. At the present time, it is not certain that serum CK-BB levels in serum can be used to predict or follow disease states.

Atypical CK Isoenzymes

The atypical CK isoenzymes are CK fractions that are not CK-MM, CK-MB or CK-BB. The atypical CK isoenzymes have been classified as anodic CK (macro CK, Type 1) and CK mitochondria (macro CK, Type

2) and have generated considerable interest because of their unusual physical and immunochemical properties.

Anodic CK Isoenzymes

The anodic CK isoenzymes can be detected electrophoretically, usually as one band but sometimes two bands migrating between the CK-MM and CK-MB isoenzymes.[28] The structures of these CK complexes have been classified as an immunoglobulin linked to a CK isoenzyme. Complexes of CK MM bound to IgA and IgM,[29] CK-MM bound to IgA[30] and CK-MB bound to IgG have been identified in patients with colon cancer, dermatomyositis and acute myocardial infarction, respectively. The anodic CK isoenzyme present in the majority of patients was identified as CK-BB bound to IgG.[32] This complex is a macro molecule with a molecular mass of greater than 250,000 and is formed as a result of binding of CK-BB to the antigen portion of the IgG molecule.[33] The CK-BB IgG complex has a Michaelis constant for creatine phosphate similar to free CK-BB[34] and showed increased thermal stability when compared to the cytoplasmic CK isoenzymes.[32]

The incidence of the CK BB IgG complex in hospitalized patients is about 1%. In our laboratory, the anodic CK complex was identified by agarose gel electrophoresis in 22 out of 2250 patient samples for an incidence of 0.9%. Thirteen patients were women with an average age of 68 years. Nine were men with an average age of 67 years. This data supports the claim that this complex usually occurs in elderly patients.[19] However, a recent report identified this complex in a six week old boy with an upper respiratory infection and in a 12 year old boy with ulcerative colitis.[3]

In patients with this complex, the total CK activity can be normal or elevated and the percentage of CK-BB IgG found in serum can be up to 100% of the total CK activity. The CK BB IgG complex can remain in serum for days, weeks and months and is not a genetic variant because it appeared in the serum of some patients who initially had a normal CK electrophoretic pattern.

Table 4
Clinical Conditions Associated with the CK Mitochondria Isoenzyme

CARCINOMAS
Stomach with metastases to bone marrow
Gallbladder
Breast
Lung with metastases to liver and kidney
Gastric
Rectal
Prostate
Pancreatic
Colon
CARDIAC
Ischemic heart disease
Acute myocardial infarct
Congestive heart failure
Angina pectoris
Cardiac arrhythmia
Cardiogenic shock
OTHERS
Cerebral hemorrhage
Alcoholic cirrhosis
Chronic obstructive pulmonary disease
Reye's syndrome
Pulmonary embolism
Malabsorption
Asthma

The clinical diagnosis of patients with this isoenzyme is shown in Table 3. Most of the patients had cardiac disorders because the CK isoenzymes were requested in order to rule out AMI. The anodic CK complex can remain in serum during the acute and recovery phases of the patient's illness, and could not be correlated with clinical condition of the patients. The wide variety of clinical disorders in which the anodic CK complex is found and the observation that this isoenzyme was also present in healthy asymptomatic individuals[35] supports the claim that this complex cannot be related to any specific disease state.[19]

CK Mitochondria Isoenzymes

The CK mitochondria isoenzymes can be detected electrophoretically in serum as one or two bands migrating cathodic to CK-MM.[28] The CK mitochondria fraction does not contain any of the cytoplasmic CK isoenzymes, or immunoglobulins because incubation of serum containing this fraction with antibodies to CK-M or CK-B or antibodies to IgG, IgA and IgM did not result in inhibition of CK mitochondria activity.[36,37]

The incidence of the CK mitochondria isoenzyme in hospitalized patients is less than 1%. In patients with this fraction, the total CK is usually elevated. The amount of CK mitochondria isoenzyme found in serum can range from 3-40% of the total CK activity. In these patients, the serum enzyme activities of lactate dehydrogenase, alkaline phosphatase, gammaglutamyl transferase, aspartate and alanine aminotransferase are usually elevated. The origin of this fraction is probably from the mitochondria because isolation of heart and liver mitochondria resulted in a CK isoenzyme with physical and immunochemical properties similar to those of the serum CK fraction.[38,39] However, in a recent report, a CK fraction migrating cathodic to CK-MM that could not be identified as originating from the mitochondria was detected in patients treated with theophylline.[40]

The clinical diagnosis of patients with the CK mitochondria isoenzyme is shown in Table 4. Patients with the CK mitochondria isoenzyme can be divided into two groups: those with carcinomas and patients with cardiac disease. Most of the patients with the CK mitochondria isoenzyme are seriously ill and survival incidence is low. In many of the patients with carcinomas, CK-BB, in addition to the CK mitochondria isoenzyme was detected. The source of this isoenzyme in cancer patients could be either from the tumor or its metastases. The appearance of the CK mitochondria isoenzyme in the serum of adults usually occurs at the end stages of the disease and indicates a poor prognosis. The CK mitochondria isoenzyme was recently identified in five pediatric patients, four of whom had myocardial muscle damage.[3] Four of the patients were discharged with a good prognosis and one patient died. The appearance of the CK mitochondria isoenzyme in the

serum of children may not have the same clinical implications as in the adult population.

Methodological Effects of CK-BB and the Atypical CK Isoenzymes on CK-MB Results.

CK-MB can be measured in serum using electrophoresis, immunochemical, ion-exchange chromatography radioimmunoassay or enzyme immunoassay techniques.

Electrophoresis: CK-MM, CK-MB, CK-BB, the anodic CK isoenzymes and the mitochondria CK isoenzymes are separated using an agarose gel or cellulose acetate medium and the CK fractions are detected fluorometrically. An advantage of the electrophoretic technique for measuring CK isoenzymes is that each CK fraction can be visualized. This eliminates the possibility of misinterpreting the CK-BB, the mitochondria CK isoenzymes and the majority of samples with anodic CK isoenzymes as CK-MB. However it is possible that the anodic CK isoenzymes can comigrate with CK-MB.

Immunochemical: There are two types of immunochemical procedures for measuring CK-MB activities. The first procedure involves inhibition of the CK-M subunits by antibodies to CK-M, measuring the residual CK-B activity, and then relating this to the CK-MB activity in the sample.[41] Samples with CK-BB, the CK-BB IgG complex and the mitochondria CK isoenzymes are not inhibited by CK-M antibodies and will give false positive results for CK-MB. The second immunochemical procedure involves use of a double antibody technique.[42] Antibody to CK-M is added to two test tubes containing the serum. A second antibody is added to one of the tubes to precipitate the CK-M antibody complexes. The residual CK activity in both tubes is determined. The CK activity in the tube, in which the second antibody was not added, is due to the B activity of CK-MB, CK-BB and the atypical CK isoenzymes. The CK activity in the supernatant is due to CK-BB and the atypical CK isoenzymes. Substraction of CK activities in the two tubes results in the CK-B subunit activity of CK-MB and in theory eliminates interferences from CK-BB and the atypical CK isoenzymes.

In our laboratory, the CK-MB activities were determined using this assay in six samples with CK-BB, four samples with the anodic CK isoenzyme and five samples with the cathodic CK isoenzyme.[43] The results showed that CK-BB and these atypical CK isoenzymes were not detected as CK-MB. Although this immunochemical procedure reduces the probability of measuring the atypical isoenzymes as CK-MB, it was reported that a false positive CK-MB result was obtained with a sample containing the anodic CK fraction.[44] The structure of this fraction was not identified.

Ion Exchange Chromatography: In these methods, serum is applied to the top of a column. The CK-MB fraction is selectively eluted from the column and the CK activity measured. Samples with the anodic CK isoenzymes will elute off with the CK-MB fraction and will result in false positive CK-MB results.[44] The mitochondria CK isoenzymes will elute with the CK-MM fraction and will not affect the CK-MB results.

Radioimmunoassay: There are two radioimmunoassay procedures that can be used for measuring CK-MB. The first procedure involves incubation of serum with ^{125}I labelled CK-BB and antibody to CK-BB. The bound fraction was separated and the immunoactive CK-B in the sample determined.[45] With this assay, samples containing CK-BB and the CK-BB IgG complex will give false positive CK-MB results.

In the second radioimmunoassay method, serum is incubated with antibody to CK-B that is immobilized on a bead. In this step, the B-subunit of CK-MB, CK-BB and the CK-BB IgG complex is bound to the bead. After incubation ^{125}I labelled antibody to CK-M is added, which binds the CK-M subunit of CK-MB. The bound radiolabelled fraction is counted and related to the amount of CK-MB present in the sample.[46] With this assay, there should be no interferences from CK-BB or the atypical CK isoenzymes.

Enzyme Immunoassay: In this procedure, serum is added to an antibody to CK-M that is immobilized on a bead, which results in binding to the CK-MM isoenzyme and the M-subunit of CK-MB. An antibody to CK-B, which is conjugated to the enzyme, alkaline phosphatase, is added and binds the B-subunit of CK-MB. The activity of the enzyme, alkaline phosphatase, that is bound to bead is determined and related to the amount of CK-MB present in the sample.[47] The CK-BB and atypical CK isoenzymes should not affect the CK-MB results obtained with the assay.

Summary

Elevated CK-MB values are sensitive and specific indicators of AMI provided that the correct time sequence for collection of blood is followed and the CK-MB results can be correlated with the electrocardiogram results and the clinical condition of the patient. CK-BB and the anodic CK isoenzyme can be detected in patients with a wide variety of disorders. The CK mitochondria isoenzymes are found in patients with carcinomas or cardiac disorders. At this time, the most important clinically significant fact of the CK-BB and the atypical CK isoenzymes is in their effect on some methods for measuring CK-MB. ◀

References

A complete list of references for, "Creatine Kinase Isoenzymes: Diagnostic Significance," may be obtained by writing the Illinois Medical Journal, Twenty North Michigan Avenue, Suite 700, Chicago IL 60602.

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MEMBERSHIP FORUM

Membership Forum is intended to serve as a communication tool for ISMS membership. The editors encourage comment and criticism on issues of the day. Material published in this section reflects the personal opinions of individual ISMS members. ISMS cannot accept responsibility for content. Publication does not reflect official policy or position of the Illinois State Medical Society or the Illinois Medical Journal. The right to edit materials, which should be limited to 300 words or less, is reserved.

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Physician Healer or Executioner?

To the Editor:

Lethal injection is gaining in popularity for executions in the United States and it is the official method of execution in Illinois. Regardless of our attitude toward capital punishment, the members of the medical community ought to find this method of execution troublesome.

Physicians (as well as other members of the health care team) explicitly or implicitly predicate their function upon the premise that they will act only in the best interest of their patient. This is true in all instances—even in those instances in which a physician is forced to render emergency care to an enemy. To act otherwise is to commit a grossly unethical act. A physician who kills an enemy with a gun is held guilty of murder; most will agree that killing the same enemy within the context of the physician-patient relationship and with the tools specific to medicine is a far more heinous crime. Why should that be so?

Throughout the ages immense power has been rightly or wrongly attributed to the society's healers. Equipped with tom-toms and incantations or equipped with pace-makers and laser beams, the power of the healer could be safely granted only with the faith that he would not use this power to harm his patient. No society, no individual could dare grant such power without this caveat. It is this presupposition alone which allows us to lie down on the physician's table fearing mishap, fearing misadventure, even fearing ignorance but never doubting the physician's benign intent. Only a paranoid would suspect that the drug injected into him by physician or nurse is a lethal poison. The physician/patient relationship is and must be predicated upon this trust if it is to endure.

When you and I went to medical school (or to any other school designed to train members of the health care team), all of our learning was dedicated to this. Our specific goals of direct patient care, research or teaching did not matter—the ultimate aim of all these activities was the direct or indirect "good" and never the "ill" of our patients.

Much has been made of the "merciful" nature of the lethal injection. Few know that the guillotine was introduced by Dr. Guillotte, a physician during the French revolution, that he was bitterly opposed to capital punishment, that he designed it as a "more merciful means" and that its very efficiency and "mercy" probably were in part responsible for the numbers killed in the Terror. Physicians are sworn to fight for sentient life and to relieve pain. Their first priority—that of prolonging meaningful life—yields to that of mercifully obtunding pain only when that priority can no longer be satisfied. The end of mercifully obtunding pain as a first priority even at the risk of shortening that life is permissible if and only if the prime goal of life can no longer be served.

Let me be very clear: my thesis is not a blanket opposition to capital punishment (albeit that I categorically oppose it); that is another matter. My thesis is that no physicain—or any member of the health care team—can ethically use those skills learned solely for the good of the patient in the course of his/her education to that patient's ultimate detriment.

A lethal injection to end the life of one sentenced to die requires, somewhere along the line, cooperation by members of the "health team." Even if a pure layman were to be specifically trained for that purpose, that training would require participation by health professionals as does research, development, manufacture and distribution of the agent used. No matter how far removed, the medical establishment is involved; no matter how slick the process of rationalization denying this, no matter how we may close our eyes and wish them closed, such involvement violates our basic trust. A society condoning its healers as executioners (Nazi Germany was one of the few states in history doing this until now) is in grave peril of losing its soul. A medical community that does not protest, perforce participates. ◀

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Legislative Package Introduced

Off and Running

Calling for a "full and fair hearing" by the Illinois General Assembly, the Illinois State Medical Society began its quest for malpractice reform last month with the introduction of a series of proposals backed by the Society.

In Springfield and Chicago press conferences on April 11, Dr. Robert C. Hamilton, who was then ISMS president, and Dr. Alfred J. Clementi, chairman of the board of trustees, said that the ability of physicians to continue delivering health care in Illinois depends upon resolution of the current crisis. The physicians cited broad based support for malpractice reform from other groups, including the Illinois Manufacturers Association, Illinois Hospital Association, Illinois Podiatric Medical Association, Illinois Association of Osteopathic Physicians and Surgeons, and Associated Employers of Illinois.

"When these bills were introduced in 1984, they were not aired fully by either house because they never emerged from committee," said Dr. Hamilton. "This cannot happen again. The growing medical malpractice crisis of 1984 is now a real crisis in 1985."

Echoing Dr. Hamilton's concern, Dr. Clementi told assembled media representatives that, "ISMS is committed to doing all we can to gain a hearing for proposed medical malpractice reform before the full state legislature. To do less," he noted, "would continue to inflict harm on all of our patients—and all Illinois health care consumers."

Both Dr. Clementi and Dr. Hamilton cited broad based support from the public and Illinois' health care professions for reforming the medical malpractice litigation climate. Nearly 400 public meetings of concerned physicians, patients, legislators and hospital administrators have occurred to date to voice concern over current imbalance in the medical malpractice system.

"The current medical malpractice crisis has a very expensive impact on health care consumers," said Dr. Hamilton. "Over $1 billion annually is now wasted on medical malpractice related costs, without bettering the quality of health care or bringing justice more efficiently to those patients truly injured by malpractice."

Dr. Hamilton also warned that if civil justice imbalance persists, the current affordability crisis of medical malpractice insurance premiums will grow into one threatening the availability of high-risk health care. "Physicians are retiring from active practice earlier. Younger physicians, unable to afford high malpractice insurance premiums, are shunning Illinois," he said. "Premiums for high risk specialties, such as obstetrics and neurosurgery, can cost physicians in some areas of the state as much as $1,000 weekly."

"In this lawsuit-prone society, frivolous litigation is clogging civil court dockets," Dr. Clementi said, "denying and delaying deliberation of valid malpractice claims and suits."

Drs. Hamilton and Clementi cited statistics from the Illinois State Medical Inter-Insurance Exchange showing that 80% of medical malpractice claims filed and closed since 1976 were non-meritorious. They stressed that the reforms "would work to clear out the underbrush of frivolous litigation without jeopardizing consumers' right to their day in court."

The Society's legislative reform package would mandate that:

- Awards greater than $50,000 be paid to injured patients over a specified time period rather than in lump sums. This would assure benefits are available when needed by the patient for future care.
- Physicians could countersue to recover damages when "maliciously prosecuted" for medical malpractice. Under current law, physicians are effectively barred from doing so, due to the provision requiring proof of "special damages."
- Non-economic awards (pain and suffering, loss of consortium, etc.) be capped at $100,000. All present and future economic losses would continue to receive full compensation.
- Punitive damages be eliminated in medical malpractice cases. The Illinois Medical Disciplinary Board is the proper forum for punitive actions against incompetent doctors.
- Juries itemize elements of a medical malpractice award to determine more accurately the patient's estimated future costs of medical care, lost wages and earning capacity, and other expenses.
- Patients receive a greater share of their medical malpractice award dollars through a sliding scale limit on attorney contingent fees.
- Expert screening panels, composed of lawyers, judges

At the Door of the Legislature

As this issue goes to press, the ISMS/ISMIE sponsored package of malpractice reform legislation is before the Senate and House Judiciary Committees. We would hope that, as you read this, malpractice legislation will be on the floor of the General Assembly for debate by both houses.

The months of May and June will see the apex of the professional liability initiative. All of our work to date will come to fruition in these two months.

Your legislators are now confronting the issues head on for the first time. Until now, they've spoken with you about the philosophical need for malpractice reform. Now they must confront the issue with their voting buttons. Either they will change the law or they won't.

In the following pages, you will find three interviews. Each features an Illinois physician whose professional life was irrevocably altered by the spectre of malpractice. There probably isn't a physician reading this who can't relate a similar story from his or her community.

Malpractice touches each of us, but more important, it touches each of our patients. This is their battle. It's our patients who are paying the costs of a legal system out of balance. They are paying in tangible ways—in higher physician fees and hospital charges to cover increased malpractice premiums; in greater paycheck deductions to cover health benefits; in the time and money associated with defensive medicine.

But perhaps the most serious costs are more subtle. Without a change in the law, our patients will lose as we physicians become more reluctant to explore unproven new treatments. They will see fewer talented young people entering the profession and many fine physicians retiring early. Those with high risk disorders will find fewer physicians providing treatment. Finally, the continuing spiral in litigation will continue to erode the mutual trust and respect that it is so important to the physician/patient relationship.

We urge each of you to share this message with your legislators. Don't assume that last month's conversation and commitment are sufficient. Your legislators are approached daily by many people with many points of view.

In the next few weeks, your legislators will make decisions on concrete proposals. They will vote to bring the system back into balance. Or they will vote against proposed reforms and an end of the malpractice crisis. Please share the facts with your legislators. For your profession and for your patients, please contact your legislators today.

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Medical Society

Fred Z. White, M.D., Chairman
Illinois State Medical
Inter-Insurance Exchange

Physicians can obtain addresses and telephone numbers for their legislators by contacting the Society's division of governmental affairs (1-312-782-1654 or 1-800-782-2749).

and physicians preview medical malpractice cases to rule on their validity before they enter the costly civil court process.

- Jury awards be reduced by the full amount an injured party has received from such collateral sources as medical insurance or workers compensation. Illinois law currently provides for a 50% offset.
- A $25,000 limit be placed on economic losses for wrongful death. This cap could be raised with supporting evidence of greater economic loss.
- Expert witnesses testifying in malpractice cases meet strict requirements to assure their true expertise. At least 75% of their time should be devoted to active practice of the defendant's specialty or to academic instruction of it in an accredited medical school.
- Physicians uninvolved in a specific malpractice incident but named, nonetheless, in the lawsuit could be dismissed by filing an affidavit attesting to noninvolvement.
- Plaintiffs or their attorneys who make untrue allegations without reasonable cause are liable for the defendant doctor's attorney fees and costs.

Although the legislation was referred to the lawyer-dominated Judiciary Committees in the House and Senate, ISMS vowed to work to overturn any unfavorable rulings and seek to have its proposals heard by the full chamber.

With a Certain Degree of Sadness

Dorothy L. Larson, M.D., was a general practitioner in Mascoutah, Illinois for nearly 35 years. A native of Mascoutah, Dr. Larson is a 1949 graduate of the University of Illinois College of Medicine. In this interview, Dr. Larson tells of the difficult decision to leave her profession rather than shift the burden of increased malpractice premiums to her patients.

Dr. Larson: I live in a small southern Illinois community by the name of Mascoutah. I have lived in this town all my life and six generations of my family have lived here. So I'm happy and comfortable with this community.

I've been practicing medicine in this town almost 35 years. And my husband practiced medicine with me for about 30 years, up until the time of his sudden death five years ago.

I have enjoyed my practice very much. Until one day in August, about 6:15 in the morning, when a sheriff's car drove up to the house and gave me a summons stating that I was involved in a malpractice suit.

All of a sudden a very dark cloud had appeared over my life and the lives of the people that are working for me in my office. In fact, the emotional trauma involved in this was almost as severe as the morning that my husband died five years earlier.

In the following days, of course, I had to take care of my patients as usual. But I also had to spend much time getting in touch with my malpractice insurance company, contacting attorneys that they had assigned to me, getting reports ready for the insurance company; in general, leading a very difficult, unpleasant life.

This issuance of the summons for this malpractice suit was a very traumatic thing in my life. But eventually I got used to the idea a little bit, and life went on.

Then in January of this year, my malpractice insurance premium arrived. This was another shock. Because I had been named in a malpractice suit, the premium had risen substantially.



With the increase of this insurance premium, it would be impossible for me to meet the payments because of the low fees that I have generally charged people throughout my practice of medicine.

I'm very well aware of the expenses that the ordinary family has in trying to keep their family healthy. I'm very well aware that when a family comes in with two or three youngsters, the antibiotic bill may run into $20, $30, or $40. In order to make their lives less burdensome I have always tried to keep my fees very low. And because I do have a modest lifestyle, I have been able to do this.

With the increased malpractice fee, I would no longer be able to cooperate in this way. So I decided that as of May first, I will quit the practice of medicine.

With the increased malpractice fee, I would no longer be able to cooperate in this way. So I decided that as of May first, I will quit the practice of medicine.

IMJ: *How did your patients feel about your decision to quit?*

Dr. Larson: When my patients first heard that I was going to quit, they couldn't believe it. They were in a state of shock because I am in good health and I have a lot of energy and this was not part of my life plan at all. And they knew that.

So at first they were shocked and then they were sad. And as each one came to the office and asked me about this—and they are still doing it every day—it's almost like attending my own wake. They are very sad because we've had an excellent relationship. I have assured them that I will have someone else to take my place. I have also told them that this individual's malpractice insurance rate is already much higher than my past insurance was, and that this individual will have to charge much more than I have been able to charge in the past.

When my patients first heard that I was going to quit, they couldn't believe it . . . And as each one came to the office and asked me about this—and they are still doing it every day—it's almost like attending my own wake.

IMJ: *Since you found out about the suit, has your attitude toward the patients changed? Has your practice changed?*

Dr. Larson: Since the malpractice suit came about, my attitude toward the patients has changed in that I realize that every time a patient steps into my office it's a potential lawsuit.

I do know that the majority of my patients wouldn't *think* of suing me. But still, the thought crosses my mind that maybe this person will be disenchanted for some small item or another, and I might be sued. And just from that standpoint there has been a slight change in my feeling toward the patients. It saddens me that I have to take this attitude, because in the past the whole relationship between myself and my patients has been very good.

IMJ: *What's your impression of how the malpractice climate has changed medicine since you started practicing?*

Dr. Larson: When we first started practicing we almost never thought of malpractice. It seldom entered our minds until we got our yearly premium, which when we started was $300-400 a year. We did not expect to get sued, we didn't think along those lines at all. It was a relationship of trust between the physician and patient. Of genuinely liking each other and not thinking in terms of what money could be extracted from an insurance company.

Of course, this gradually deteriorated. Now patients and attorneys are all well aware that we have malpractice insurance, and if an individual is clever enough, that insurance can be tapped into.

IMJ: *Is the same general kind of thing happening in your hospital?*

Dr. Larson: This same feeling is present throughout the *entire* medical profession. In the past, when we gathered in the doctors' room for coffee, the main discussion would be about the individuals who came through the emergency room who were very sick, or we would talk about problem cases, diagnostic problems.

Now almost the entire conversation deals with articles in the paper about malpractice, about newly filed suits against doctors who are sitting in the group, or worrying about the various patients who may or may not have reason for filing suit. The whole trend is worrying about what's going to happen next.

IMJ: *If all of this had not occurred, would you still have contemplated retiring?*

Dr. Larson: If all this hadn't occurred, of course I wouldn't stop practicing. I hadn't even *thought* about quitting. In fact, I hadn't looked down the road to the point of time that I would quit. But the relationship with the patient and the higher costs that I would have to pass on to the patient makes the

entire practice of medicine less fun.

Medicine used to be fun and gratifying. It still is, largely, but in the background is the shadow of malpractice. It's like a cloud that is always over a person.

IMJ: *Have you accommodated yourself to the idea of retiring?*

Dr. Larson: I have adjusted myself to the idea of retirement because I see no way out. I am realistic enough to know that we have various chapters in life, and it looks like this chapter is closing for me. So I'll just wait and see what the next chapter is. I'm not ready to retire from the planet.

IMJ: *Based upon your own experience, do you think young people still will want to choose medicine as a career?*

Dr. Larson: Well, in spite of it all, I guess a person would still go into the practice of medicine because of a liking for taking care of people. It wouldn't be with the same degree of ease and enthusiasm that a person did when I started practice because the situation has changed entirely. I suppose a person would still go into medicine, but with some misgivings—and a certain degree of sadness.

But I Took Care of this Patient

Courtney P. Jones, M.D., is a board eligible internist who serves as medical director for an East Chicago, Indiana, steel company. Dr. Jones, who maintains a small internal medicine private practice in Blue Island, Illinois, was in full time private practice from 1967-1980. A 1962 graduate of the University of Illinois College of Medicine, Dr. Jones shifted to part time occupational medicine in the wake of a malpractice suit. In this interview, Dr. Jones tells why he felt compelled to shift his practice mileu.

IMJ: *What changes have you observed in the malpractice and legal/medical climates since you began practice?*

Dr. Jones: Well, to give you an idea, when I entered into practice, my malpractice insurance cost me $79. It is now close to $4,000 for only part time practice.

When you talk to other doctors, you hear an orthopedist tell of paying $42,000 just for the privilege of taking care of a patient. You hear that a gynecologist pays $37,000 per year just for the privilege of taking care of someone. And they feel it's a good year if they get away without any suits. You sit up and say, "Hey, that's more than the average person earns; that's an awful lot of money being spent just to keep from being sued."

I've watched relationships with patients change almost to where, when a patient comes in, especially a brand new person—your first thought is to make sure you cover all bases. That's almost like being in an adversarial relationship with your patient. Because the basis, the very crux of a patient/doctor relationship, is one of mutual trust. You trust that the patient will tell you what the problem is so you can help the person. The patients trust you because they want you to give them some relief from the problem that they're having.

I've been in practice now something like 17 years. In these 17 years I have watched more and more doctors become upset. It's not verbalized in the community, but it's there. Before they would say, "Oh, well, this will pass," and they'd push it off to the side, but now it's becoming something that people are really alarmed about.

Now it's not just doing the level best for your patient. It's making sure that some lawyer will not come up and say, "Did you do this?" It's becoming ridiculous.

IMJ: *A malpractice suit against you was thrown out of court as unfounded. When you received notice of the suit and started to realize what you were up against, what was your emotional reaction? How did you feel?*

Dr. Jones: I couldn't believe it. The first question you want to ask is, "Am I on *Candid Camera*? Is this for real? Is somebody trying to play a practical joke?" Then you look at the name of the person and say, "But I took care of this patient." In your mind you say, "What is this all about?"

IMJ: *After the disbelief, what started to go through your mind then?*

Dr. Jones: Anger. Sheer anger. I can't even repeat what my thoughts were.



IMJ: *Did you ever begin to question yourself, why you were doing what you were doing?*

Dr. Jones: One always questions, and I'm one of my best critics. You question what you did wrong—this comes before the anger. You wonder, "Why would this person name me?" You put them in the hospital, you go through their problem with them, you examine them, you try to do all the appropriate tests commensurate with the illness that they bring in; and then you question yourself, "What did I do? Was my bedside manner so bad that I didn't really maintain a good rapport, good relationship with the patient?"

All these things you think about. And if you think about it, and you know that what you've done was right, somehow you get very angry.

Either you're going to end up without very good medical care or you're going to end up with a situation where only a few people can afford to go to a doctor.

IMJ: *As a result of that experience, how has your practice changed?*

Dr. Jones: Well, I think I used to be a very daring young doctor trying to conserve monies and all that stuff. I've become a lot more conservative—ordering tests to make sure. Even to the extent that if I feel that a bone isn't broken or certain things aren't going in a particular direction, I'll still order an x-ray or a blood test just to have it on record that this is the case.

In my practice, it got to a point where I was seeing many, many welfare patients. And I just stopped taking welfare patients and got into occupational medicine, because it was one of the patients on welfare who sued me. You're not really reimbursed for all the effort that you put into taking care of a welfare patient. And then being sued; it left nothing but a terrible taste. Now I'm just trying my darnedest not to let that happen to me again. There's no way, though, to prevent it.

The first question you want to ask is, "Am I on Candid Camera? Is this for real? Is somebody trying to play a practical joke?" Then you look at the name of the person and say, "But I took care of this patient." In your mind you say, "What is this all about?"

I also was accustomed to doing some invasive procedures as an internist. They were just normal things, and then all of a sudden I sat up and realized that I was exposing myself to suit. So I began to back away from that.

IMJ: *If we don't succeed in getting some legislative reform, what do you think the consequences will be?*

Dr. Jones: Like anything that's running amok, you can have any variety of things. Either you're going to end up without very good medical care or you're going to end up with a situation where only a few people can afford to go to a doctor.

I think that the malpractice situation in the United States as it exists now is a very destructive thing in our economy.

I was looking at statistics from the Illinois State Medical Society which indicated $725 million in the state of Illinois is estimated to have been spent in defensive medicine.

You know with the problems we have in just our educational system here, the poverty that we're having, it's really terrible that we're spending money that way.

The next thing is that many doctors are leaving the practice of medicine. One doctor I know left the practice of medicine behind after a suit. And he was talented. He taught me in school. A very brilliant man. When I think of all that talent just being lost that could give something . . . it's not just him, a lot of other people with good skills are going to be lost.

The malpractice situation stinks, and until the lawyers face up to their responsibilities as well as the doctors and the insurance companies and the politicians, we are going to have problems. And these problems are not going to go away by themselves. ◀

The Cost of Doing Business?

Sara C. Charles, M.D., is a board certified psychiatrist and associate professor of clinical psychiatry affiliated with the University of Illinois College of Medicine at Chicago. An associate examiner in psychiatry for the American Board of Psychiatry and Neurology, Dr. Charles took two years from private practice to research and study the effect of malpractice litigation on the physician. In conjunction with her husband, Eugene Kennedy, Dr. Charles has written a book on her experience which will be reviewed in an upcoming issue. "Defendant: A Psychiatrist on Trial for Medical Malpractice," will be published later this year by The Free Press of MacMillan, New York. In this interview, Dr. Charles discusses the results of her research.

IMJ: *Is it really a malpractice crisis that we're talking about?*

Dr. Charles: I think that's a misnomer. It is *not* a malpractice crisis. We all know that in this country we are getting the best medical care the world has ever seen. We have doctors who are highly trained. We have the epitome of medical practice. What we're really seeing is an explosion of litigation against physicians. I would term it more a *litigation* crisis.

The rationale that's given for the explosion in litigation is that asserting, and eventually, proving malpractice weeds the bad doctors out of medical practice. That's far off the mark. That's a wonderful thing to say, but to accuse—as they are in the state of Illinois—almost one out of every two doctors at some time or another means that there's no such thing as a good doctor.

IMJ: *Some lawyers say that we have a higher incidence of suits because we've got a more educated public and they're finding out what doctors are doing wrong. Is that why we have a malpractice crisis?*

Dr. Charles: That's certainly one facet of it. But this is a multi-faceted problem. There's no question we have a more highly educated public. But the same more highly educated public also expects perfection.

Let's look at it this way. First of all we have in our society young people who have never been ill, who look upon health as a right, that it's to be expected, and that if they exercise and eat the right foods and don't smoke, they're going to be well. But that's not necessarily so.

There's also the presumption that people who come to doctors are well to begin with and doctors make them sick—which, of course, is preposterous. Added to this is the fact that Americans have a sense that if anything goes wrong someone ought to pay for it. That may be a philosophy that everybody agrees with, but we may not be able to afford it.

IMJ: *Can we follow up a little bit on the compensation aspects?*

Dr. Charles: There's a long history of antagonism between the law and the insurance industry. Still, insurance is a relatively new phenomenon in terms of compensation for injuries that derive in certain sectors of society. For instance, in the late 1800's, there was a movement whereby industry began insuring itself against injuries that occurred in the workplace. As machinery began to be developed, and the workplace became more dangerous, people began getting their eyes injured and limbs lost. And they would try to get some kind of compensation.

But there wasn't any compensation for them. So they tried to use the law and the legal system to get access to compensation. And the tenor of the courts was very much that the common good was in the hands of industry rather than the individual. So there gradually developed out of this a state-by-state phenomenon—workman's compensation. And it side stepped negligence charges except in specific kinds of injuries.

Now what attorneys are doing in health care is using what they say are tried and true tort laws to enable people who suffer injury just chance for compensation. In order to do that, they have to personally accuse the physician, because that's the nature of negligence law. The insurers are not just going to hand over this money without a fight. So the law provides that.

IMJ: *But when a doctor is accused of malpractice what does it do to him emotionally?*

Dr. Charles: I think many in the legal profession and many in insurance will say, "Look, doctor, this is the way business is in America today, and you're in a business whether you like it or not. You may *perceive* it as a profession but it's really not a profession, it's a business. And every business has to be responsible for its product. Your product happens to be health care. So don't take it personally. It's just the cost of doing business."

But if you've ever read a complaint, it almost accuses the doctor of murder. As though he went to medical school with the intention of learning how to hurt people. The complaint basically says that you may have trained all those years to be competent, but you, personally, are no good at it. You have made a blunder. You've made a mistake. And often it says that you did it with malice in mind. That's a very hurting kind of experience for a doctor.

IMJ: *Obviously, being a defendant in a malpractice suit had a great impact on you, so much so that you took time out to research the malpractice problem. Do you care to talk about your own experience?*

Dr. Charles: It certainly affected me. It made me angry first because it was with a patient I had invested a lot in. And it was with a patient that I believed in. To be sued by that patient was very hurting.

At the time, I didn't say much about it. I just went through the legal process and vented most of my rage and spleen on the lawyers who were around me. And they were very nice about it—accepting my rage.

ture to see if anyone had talked about the psychological aspect of this thing. And I found there wasn't anything. Nobody had written about it. And yet it obviously had happened to all these doctors.

We did a lot of library research on the history of the insurance industry and the history of tort law in America, and we then decided to survey physicians to see what their reactions were. We devised this survey from our impressions of talking to different people, and what the survey really reinforced was that physicians were having major feelings about this.

IMJ: *What kinds of feelings?*

Dr. Charles: Well, first of all, of course, as a psychiatrist, I was interested in the emotional reactions of physicians. We took a list of symptoms that are characteristic of depression or emotional disruption—such things as insomnia, loss of appetite. We asked about physical illnesses, whether they had any headache, gastro-intestinal changes, etc.

In general, about 96% of the physicians said they had some kind of reaction. Only four percent said

this had happened to them.

We got a lot of data from that first survey. Then we went to Dr. Alfred Clementi, who was the president of the Chicago Medical Society. He agreed to cooperate with us in doing a second survey of physicians. We wanted to see if physicians who had been sued had different reactions, not only symptomatically but in terms of their practice behaviors, than physicians who hadn't been sued. So we devised a second survey pretty much on the model of the first one, which we sent to a random sample of a thousand physicians of the Chicago Medical Society. About 56 percent of those had been sued. Given the nature of what we were asking, we got what I thought was a pretty good response rate—36 percent.

We got very much the same results in terms of those who had been sued. But what was interesting was that those who had not been sued,



The problem with the doctor is he's dealing with life and death every moment. And he can get a beeper signal where in two minutes he has to make maybe the most important decision of his life. He can't get a continuance. And he can't go to the law library and look it up and see what other people have done. He's got to do it right then. And then he has to live with that.

But I really felt that I was being a good doctor, and so I was not going to settle. And I had the option to go to trial. I went to trial and won. During those years I had a couple of experiences where I had the feeling other doctors were suffering enormously but quietly, and nobody would say anything about it. So I did a search of medical literature to see if anyone had talked about the psychological aspect of this thing. And I found there wasn't anything. Nobody had written about it. And yet it obviously had happened to all these doctors.

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In general, about 96% of the physicians said they had some kind of reaction. Only four percent said there wasn't anything to it. And some of the reactions were extraordinary. We had three who indicated that they had coronary occlusions during this phase of litigation. We had a good number who had symptoms of what a psychiatrist would say is associated with a major depressive disorder. The most common reaction was anger—rage that but feared suit, also were fairly symptomatic in terms of losing sleep over certain patients. We had doctors who said, "I'm an obstetrician, and I've never been sued but I have two babies that I've delivered who have cerebral palsey and there's 19 years on the statute of limitations, so I'm worried." That sort of thing.

IMJ: *How does all this hurt affect the physician's relationship with his patients?*

Dr. Charles: Many people who have studied the medical profession have suggested that you really can't even treat sick people unless you do it in the context of the doctor-patient relationship. Inherent to that—whether we like it or not—is a feeling of mutual trust.

It's kind of like a parent and a child. If a parent says to his son, who wants to be a doctor, "I just don't think you're that good," that child can have bad feelings about himself the rest of his life. And yet when a father communicates to his son or his daughter that the sky's the limit, it makes for a very different experience. That's a psychological kind of non-measurable experience, but I've had many people sit in my office for the very reason that they didn't feel anybody trusted them.

The doctor and the patient have to trust each other. But any doctor who's been sued has a gut feeling now about patients. Are they going to believe in me? Can I invest myself in them? If you invest yourself, it's like any other human relationship. You leave yourself open to be hurt in any relationship that you invest yourself in.

Anybody who's had a serious illness will tell you that the thing that is most helpful is the feeling that their doctors know what they're doing. Now, again, the intent of litigation and the accusations which are in complaints are geared to make you doubt yourself—you could have done some other thing, you could have used some other approach, or you might have done it another way. And that's very hard. You can't operate if you doubt yourself. You simply can't do it. You can't go into neurosurgery and say, "I wonder if I'll know what to do when I get in there."

People have to understand what it means to be a doctor. The problem with the doctor is he's dealing with life and death every moment. And he can get a beeper signal where in



two minutes he has to make maybe the most important decision of his life. He can't get a continuance. And he can't go to the law library and look it up and see what other people have done. He's got to do it right then. And then he has to live with that.

IMJ: *But the question still remains. Why the fuss? Why can't doctors be just like business people? Why can't they just expect that they're going to be sued? Shrug it off and go about their business. Is there something special about them? Why should they be treated differently?*

Dr. Charles: I don't think it is what is different about them. I think the difference is in the nature of what they do. We've done some research recently and found that physicians are not only naive about business matters, but most are very uncomfortable in running the business part of their profession.

There are so many forces that say, "Let's make it a business." But care of the human being will never be a business. Even though everyone is saying it's a business now. It's *not* a business.

My concern as a physician is that the physicians whose interests were helping people are becoming so overwhelmed and stressed by the so-called business aspects of medicine that they're very unhappy. They are not able to do what they want to do.

The physician, in order to exercise his profession, needs freedom—the freedom to make a decision that is in the best interest of his or her own patient. And the patient has to believe that he or she is going to make that best choice. Otherwise, they ought to go to some other physician.

Let me give you an illustration. An OB/GYN said to me that he doesn't do obstetrics anymore. An old patient of his with whom he had a very good relationship and whose babies he had delivered was pregnant again, and they were talking about plans for the birth of this child. And the woman said to him, "if anything goes wrong I don't want you to use high forceps." And he said, in that instant, it all changed. Because what she was saying to him was "I don't believe that if we come to a crisis you'll make the best choice for me." You have to have the patient believe in that and you have to believe in yourself that you will make that best choice. But you have to have the freedom to make the choice.

There are so many forces that say, "Let's make it a business." But care of the human being will never be a business. Even though everyone is saying it's a business now. It's not a business.

Now what lawsuits do, for instance, is reduce medical care to a level of mediocrity that will fit every case. So that if you have a child come into the emergency room with a hit on the head, you have to do an x-ray. The incidence when they really find something is very limited. But for legal purposes, every doctor takes those x-rays just in case he's hauled into court sometime. So he's not using his best judgment. What he's

doing is what the lawyers say he has to do—just in case.

A doctor in American society is not allowed to fail. Because if you fail once you get hauled into court. So we're naturally going to end up with not exploring the limits as we had been able to do. Exploring limits has enabled us to achieve a great deal in health care.

IMJ: *The way you present the problem, it sounds as though it's almost impossible to solve. Is it?*

Dr. Charles: It's a major cultural problem. I think what we have to do is let the public know this is happening. Because they are the losers. Of all premium dollars collected, injured patients probably only get maybe 25%. So the patients are not being well served.

What is the solution? The public first of all has to know and then make some changes in society. The public has to address whether we deserve compensation for everything that happens in life . . . and compensation to the degree that is being given. That's a big question.

IMJ: *What happens if we don't address the problem?*

Dr. Charles: Whenever you begin to tell the future, you're guessing. But we have evidence that, for a whole lot of factors, there's a decrease in applications to medical school. You don't go to medical school to spend your life in the courtroom.

Medical students are asking, is there really a future? If I have to come up with a hundred thousand dollars for a premium before I can even enter private practive, is there really a future for me? Should I really go ahead?

That's a very hard question and I think we're finding from our research that doctors are having a great deal of trouble dealing with that question—especially when it comes to their own children, formerly one of the big pools of physicians. Many physicians today had relatives in their families who were members of the medical profession. Interestingly enough, many of them are now saying to their children, "don't do it."

. . . But if you've ever read a complaint, it almost accuses the doctor of murder. As though he went to medical school with the intention of learning how to hurt people. The complaint basically says that you may have trained all those years to be competent, but you, personally, are no good at it. You have made a blunder.

We know already that physicians are moving out of private practice into more corporate kinds of medical practice. And I think you have to expect less economic results from medical practice in the future. I wouldn't go into medicine if I wanted to earn the best living available from an economic point of view.

If we ask in a survey question, whether there are any patients you won't see because of fear of litigation, you get almost 50% of the physicians who answer saying, "yes." That means—usually on a kind of gut-feeling basis—they're excluding certain people that they feel might sue them. These are individual decisions made by individual practioners, and we have not documented this very well. But we have some indications as to who they're excluding and for what reasons.

Because of the nature of our medical care system, if a doctor says, "I think you need to see another kind of doctor," or, "Maybe I'm not the doctor for you," there's a lot of doctors around so patients can go someplace else. But more and more patients may be excluded. For instance, it may be patients who are on public aid, or Medicare. Or it may be patients who are perceived by the physician to have certain life threatening or psychiatric illnesses. If you begin to exclude segments of society for fear that they're going to sue you, that's unprecedented in American history.

What we have in some sense finally achieved in our culture is fairly even access to an even standard of care. In other words, the physician has to use the same standard of care for the patient who has absolutely no income as for the patient who is the head of a big corporation. They get the same triple bypass. They get the same nurses, same doctors, all the service personnel. Right next to each other in a hospital. In the recovery room. It's extraordinary. And I think we have evidence of the shrinking of this availability, and we have evidence of the beginnings of a very subtle and, only newly measurable, deprivation of care to segments of society.

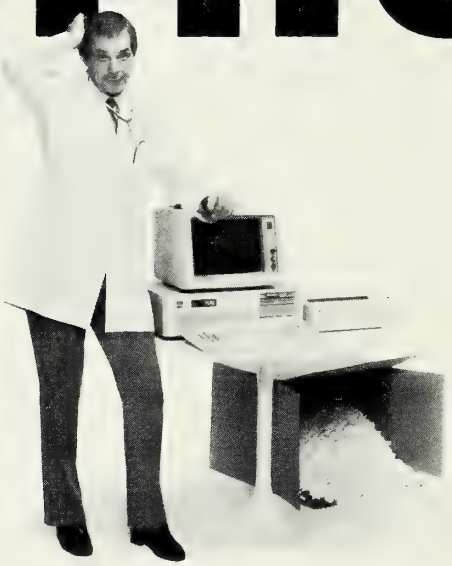
IMJ: *One final question. When you consider this issue as a whole—everything that you've been through, everything that you've seen, if you could address the general public, what would you want them to know about the problem?*

Dr. Charles: First of all I would say all the things I've said already. I also would want them to know that it's not a simple issue. I think it's an enormously complex issue.

It is not a battle between doctors and lawyers. And if you perceive it that way, you're misreading the whole thing. It is not a purely economic issue. Because if you see it that way that's a very limited vision of what's really going on. It's a cultural problem. There are basic philosophical issues that the American public has to address and has to answer. That may mean very difficult choices and enormous ramifications in the long run for American culture. ◀

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MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Greater emphasis in the non-drug regimen for mild hypertensive patients is advocated. These include weight reduction, sodium restriction, potassium, calcium and magnesium supplementation, dietary modulation, exercise, relaxation therapy, and moderation of alcohol use. These prophylactic measures may suffice to reduce the need for anti-hypertensive medications in mild hypertensive patients. (Kaplan, N.: *Ann Int Med* 102#3:359-73, 1985)

The metabolite of nicotine in the urine was evaluated in non-smokers exposed to a smoking environment in the home or in the workplace and found to be elevated. Cotinine was significantly elevated in the urine in non-smokers when exposed to the environment of smokers. The deleterious effects of passive smoking may thus occur in proportion to the exposure of non-smokers to smokers. (Matsukura, S., *et al: N Engl J Med* 311#13, 828-32, 1984)

The risk factors for cardiovascular disease were evaluated in 792 men for a period of 13.5 years. Blood pressure, smoking, serum cholesterol, and fibrinogen levels were measured. Hypertension and fibrinogen were risk factors for stroke, and smoking was closely related to elevated fibrinogen levels. Fibrinogen levels were significant for infarction but less so without hypertension, smoking and elevated cholesterol levels. (Wilhelmsen, L., *et al: N Engl J Med* 311#8,501-5, 1984)

Plasma norepinephrine levels in patients with chronic congestive heart failure were found to be significant prognostic indicators for cardiac performance. In one study, 106 patients had their plasma norepinephrine levels measured at supine resting point. An elevated norepinephrine level was the only significant factor compared to sodium and stroke-work index (at average age of 54.8) that had a deleterious effect on longevity. (Cohn, J., *et al: N Engl J Med* 311#13:819-23, 1984)

Long term estrogen replacement therapy offered significant protection against bone loss and fractures. A significant difference was noted in the skeletal mass yet did not offer the same degree of protection in all parts of the skeleton. The appendicular skeleton appeared less protected than the spine in patients receiving the estrogen replacement therapy. (Ettinger, B., *et al: Ann Int Med* 102#3:319-24, 1985)

The screening technique for occult blood in the stool should precede a digital rectal exam, and can accurately detect bleeding colorectal lesions in 90% of cases when the filter paper shows blue in even one of six samples of stool tests. These positive cases then should be referred for a double contrast barium enema and proctosigmoidoscopy. (Rakel, R., *et al: Primary Care and Ca,* 4:70-7, 1984)

Vascular headache classified as classic or common migraine and cluster headaches are characterized with prodroma of vasoconstriction followed by vasodilation. These are best treated with the prophylactic use of propranolol. Different Ca entry blockers were evaluated and nimodipine was found to be most effective. (Meyer, J.: *Ann Int Med* 102#3:395-7, 1985)

Male coffee drinkers inbibing more than 2-3 cups of coffee per day showed an increased risk for cardiovascular disease as evidenced by an elevation of the plasma concentrations of apolipoproteins B and the LDL-cholesterol levels. These levels were not elevated with less than two cups of coffee. (Williams, P., *et al: JAMA* 253#10:1407-11, 1985)

Sciatic radiation in low back syndromes is often confirmed with computerized tomography, electromyoneurography, myelograms, discography and venography. Selective nerve root injection is described in 19 cases with an unclear diagnosis and helped in their diagnosis. (Bundens, D., Rechtine, G.: *Orthop Review* 14#2:45-9, 1985)

Epstein-Barr virus infections may be associated with long term pharyngitis, lymphadenopathy, fever, headaches, arthralgia, fatigue, depression, dyslogia, and myalgia. Twenty-six adults and 18 children under 15 years of age exhibited these syndromes rather than infectious mononucleosis. Antiviral capsid antigen and anti-early antigen titers were significantly greater. (Jones, J., *et al: Ann Int Med* 102#1:1-6, 1985)

An evaluation of the QT interval in 865 patients discharged and followed for at least one month revealed that death occurred within one year in 10 of 43 cases where the QT interval was greater than 440msec. This was more significant in those without medications that may influence the QT interval. (Ahnve, S., *et al: Am Heart J* 108:395-400, 1984)

Minimally diseased coronary arteries should not be bypassed since accelerated progression of atherosclerosis is known to occur in surgically bypassed coronary arteries in which the preoperative stenosis was greater than 50%. A follow up period of 37 months in patients with less than 50% stenosis showed a 10 fold increase in stenosis of 25% or more. (Cashin, W., *et al: N Engl J Med* 311#13:824-8, 1984)

A comparative evaluation of electroconvulsive therapy and antidepressant medications in depression showed that electroconvulsive therapy achieved a recovery rate of 80-90% as contrasted to the medicinal recovery rate of 60-70%. ECT was particularly useful in patients severely suicidal, debilitated, agitated, homicidal, or whose occupation demanded a rapid recovery. (Wackym, P., Prakash, R.: *South Med J* 77:1073, 1984) ◀

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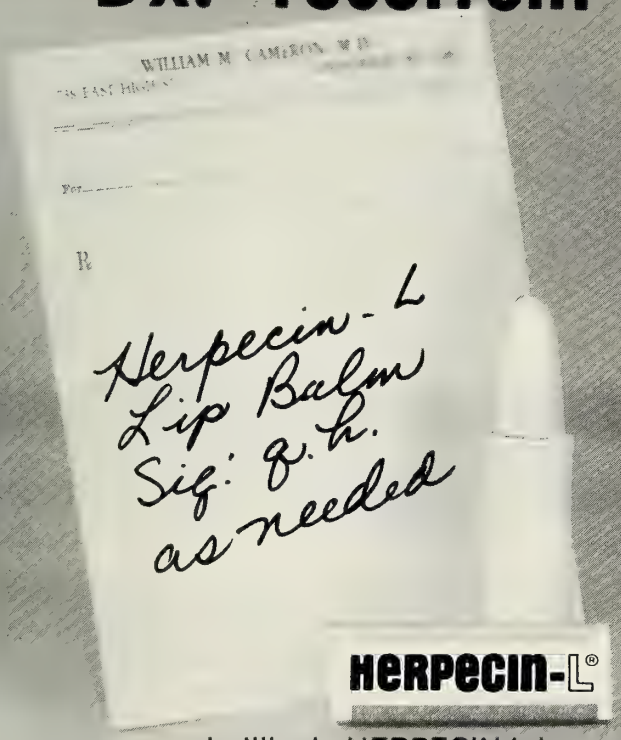
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DOCTOR'S NEWS

PHYSICIANS IN THE NEWS

The American College of Physicians has announced that **Rolf M. Gunnar, M.D., F.A.C.P.,** professor and chairman, department of medicine, Loyola University Medical Center, was elected treasurer of the College at their recent annual meeting. . . . **Lois T. Matsuoka, M.D., F.A.C.P.,** Springfield, was one of six physicians awarded a traveling scholarship by the College.

A number of Illinois physicians were named fellows of the College at their annual meeting. New fellows included: **Ashok K. Agarwal, M.D.,** Carbondale; **James A. Cowan, M.D.,** Champaign; **John T. Daugirdas, M.D.,** Chicago; **Albert C. England, III, M.D.,** Urbana; **Gershom K. Greening, M.D.,** Springfield; **Alan K. Hatfield, M.D.,** Champaign; **Russell E. Howard, M.D.,** Evanston; **Hamid M. Humayun, M.D.,** Westmont; **Wilfred Lam, M.D.,** Springfield; **Shahid I. Mufti, M.D.,** Carmi; **S. Santhanam, M.D.,** Lisle; **Thomas F. Tse, M.D.,** Fairview Heights; and **Nicholas J. Vogelzang, M.D.,** Western Springs.

ISMS past president **David S. Fox, M.D.,** Chicago, has been elected president of the Illinois Foundation for Medical Review (IFMR), formerly the Chicago Foundation for Medical Care (CFMC). Dr. Fox is also a past president of the Chicago Medical Society and a current member of the ISMS delegation to the AMA. The Foundation represents over 5,000 practicing Illinois physicians and has 13 years' service as a physician sponsored medical peer review organization. The other officers of IFMR are **Andrew Thomson, Jr., M.D.,** Evanston, vice president; **H. Constance Bonbrest, M.D.,** Chicago, secretary and **Audley F. Connor, Jr., M.D.,** Chicago, treasurer. Foundation membership information can be obtained by writing IFMR, 332 S. Michigan Ave., Suite 858, Chicago IL 60604 or calling (1-312-341-0217).

HOSPITAL MEDICAL STAFF SECTION TO MEET

The AMA Hospital Medical Staff Section will hold their fifth assembly June 13-17, 1985, at the Hyatt Regency Hotel, Chicago. The group has certified over 2,000 individuals representing 1500 of the nation's hospitals to date. Hospital medical staffs wishing to send a representative to the assembly may contact the ISMS division of membership/marketing and public relations for further information: (1-312-782-1654).

MEETINGS ANNOUNCED

The Alaska State Medical Association will hold their annual convention June 5-8, 1985, in Haines, Alaska. Scientific programs will be featured. Further information may be obtained by contacting Martha MacDermaid, the executive director (1-907-562-2662).

The American Geriatrics Society and the American Federation for Aging Research will meet July 11-12, 1985, at the Sheraton Centre, New York, New York. Clinical and ethical issues in geriatric medicine will be the focus of these meetings, which immediately preceed the XIII International Congress of Gerontology. Further information may be obtained by contacting the American Geriatrics Society, 10 Columbus Circle, Suite 1470, New York NY 10019; (1-212-582-1333).

PAIN RESEARCH VOLUNTEERS SOUGHT

Northwestern University Medical Center researchers are soliciting volunteers with head and neck pain (including face and mouth disorders) to participate in studies on pain diagnosis and control. The study will be conducted by J. Peter Rosenfeld, professor of neurobiology and psychology, and Harold T. Perry, D.D.S., professor and chairman of orthodontics at the dental school. Physicians wishing to refer patients for the study may contact the coordinators at (1-312-491-3629) or (1-312-266-5952).

ADULT IMMUNIZATION HANDBOOK PUBLISHED

The American College of Physicians has published a reference guide to help physicians meet the vaccine needs of adult patients. Copies may be ordered through the College by writing: Adult Immunization, PO Box 7777-R0325, Philadelphia PA 19175. Checks payable to the American College of Physicians should be enclosed; cost per copy is $10 for 1-5; $8 for 6-20 and $6.50 for 21 or more copies of the *Guide for Adult Immunization.*

Prairie State Games

Physician volunteers are needed to provide medical coverage for athletes competing in the regional and state events of the Prairie State Games, an Illinois Olympic-type event to begin in early May and run through the end of July, 1985. Interested physicians are urged to contact Edward Grogg, M.D., Medical Director, Prairie State Games, 160 N. LaSalle, Suite 2000, Chicago IL 60601 (312-793-4400).

Institute of Medicine Offers Prize

The Institute of Medicine of Chicago is offering an annual prize of $750 for the best thesis for original research work in the field of orthopaedic surgery completed in 1985. The competition is open to physicians who received their degrees six years or less prior to July, 1985, excluding terms of active duty in the armed forces. The greater part of the research work must have been done in a metropolitan Chicago institution. Manuscripts must be submitted by November 15. Contact: The Institute of Medicine of Chicago, 332 S. Michigan Ave., Chicago, IL 60604.

Cancer Society Sponsors Conference

The American Cancer Society's Second National Conference on Diet, Nutrition and Cancer has been scheduled for September 5-7 at the Shamrock Hilton Hotel, Houston, Texas. The Cancer Society is applying for 15 hours of Category 1 continuing medical education credit for the program. Topics slated for discussion include: The Role of Diet and Nutrition in Cancer; Diet and Nutrition in Cancer Causation and Prevention; Patient Assessment (Evaluation and Management), Cancer Patient Nutritional Support; Fact and Fallacy—Diet, Nutrition and Cancer. For further information contact: American Cancer Society, Second National Conference on Diet, Nutrition and Cancer, 90 Park Avenue, New York, NY 10016.

AMA Conducts Census

Physicians are encouraged to participate in the American Medical Association's Physicians' Professional Activities Census. The PPA Census is conducted by the AMA every four years for the purpose of identifying practice specialties and current professional activities of every physician in the country.

All physicians were to be sent a special census form which will enable accurate classification in official AMA records and in the American Medical Directory. The AMA classifications usually serve as the basis for the distribution of educational information from the AMA as well as complimentary journals and material from pharmaceutical companies.

HCFA Revises Durable Medical Equipment Payments

The Health Care Financing Administration has revised payment guidelines for Durable Medical Equipment supplied under the Medicare program. "The changes will cause physicians to change the way they write prescriptions in order to allow the Medicare eligible patients to be reimbursed for durable medical equipment expenses," according to Daniel K. Wilson, regional reimbursement coordinator for National Medical Homecare. As of February 1, 1985, payment will be made based on the Medicare carrier's decision regarding whether equipment should be rented or purchased.

U.S./Soviet Physicians Campaign Against Nuclear War

A team of leading U.S. and Soviet physicians visited several U.S. cities during February to call attention to the medical dimensions of nuclear war. The tour was a collaborative effort of the International Physicians for the Prevention of Nuclear War and its two largest affiliates, Physicians for Social Responsibility and the Soviet Committee of Physicians for the Prevention of Nuclear War. Organizers of the visits said they represent "the beginning of a series of reciprocal, nonpolitical campaigns designed to show people on both sides that Russian doctors and American doctors agree on the most important medical issue of our times—that the only antidote to nuclear weapons is to work for their elimination." ◀

MD POPULATION GROWS

The AMA has reported that the total U.S. physician population has passed the half million mark. According to AMA data for the 1982 (the most recent complete information available) the physician/patient ratio shrank from 703 to one in 1960 to 470 to one in 1982. More than half of 1982 U.S. physicians were age 44 or younger. The proportion of female physicians doubled between 1963 to 1982, to 12.8% of the total MD population.

Communicate: Together We Can Make a Difference

Communication, Investment and Progress

By Vivian V. Reardon, ISMSA President

One year ago auxiliary members received the challenge to "Communicate: Together we can make a difference." Communicate they have and that activity has accomplished much across the state in 1984-85.

Involvement does tip scales. We worked together communicating with our legislators. We added strength to the "voice of medicine" by letting them know that we were concerned about the quality of medicine. We talked, we wrote and we worked closely in conjunction with the ISMS to promote community awareness about malpractice and its relationship to health costs. We continue those efforts, for the chapter is not closed.

Programs across the state heightened public awareness of medical concerns and health issues. Auxilians continued programs in schools and community centers. The "Shape Up for Life" program encouraged better health through a positive life style. Drug and alcohol abuse, parenting, child abuse, drunk driving and organ donation were among concerns addressed. New programs were aimed toward older Americans, the largest expanding group today. A Medi-File Card was developed to aid in the proper use of medications. One county filled a need by making convenience bags for wheelchairs and walkers. The scope was broad with programs for every segment.

Greater focus was directed toward support systems for the medical family. A newly formed family advocacy committee is developing spouse support programs in the areas of drug and alcohol impairment, effects of malpractice on the family and coping as a widow or widower. Addressing stress and the uniqueness of the medical marriage, we participated in panels and seminars for medical students and residents.

Changes have brought solid investments in our future. We moved our home along with ISMS to new headquarters in Chicago. Along with that physical move came provisions for a freer flow of information between the auxiliary and our parent organization. Working in tandem with ISMS on projects and toward mutual goals is a greater reality.

Efforts to provide members with greater opportunity to participate in the affairs of the organization resulted in establishment of reference committees at the 1984-85 annual meeting. This change gives each an opportunity to influence the business and future direction that we will take.

In our communities, we have raised thousands of dollars for local medical scholarships. We again joined ISMS in fund raising efforts for the Medical Student Loan Fund. We pursued new avenues in fund raising for AMA-ERF. We have shown that "medicine cares."

For auxiliary, this has been a year of communication, of progress and of solid investment in our future. We have communicated the messages of medicine to our communities and with each other. We have mattered, we have been productive, and together, we have made a difference! ◀

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The Final Weeks

At the eleventh hour, physicians statewide were working at a feverish pace to pass medical malpractice reform legislation in the Illinois General Assembly. By mid-April, the Illinois State Medical Society had documented more than 400 public meetings about malpractice among physicians and other groups.

Legislative battle lines were drawn on April 11, when separate news conferences were held in Springfield and Chicago. Drs. Robert C. Hamilton, who was then ISMS president, and Alfred J. Clementi, ISMS Board of Trustees chairman, announced the introduction of the ISMS reform legislation.

Both press conferences generated significant coverage of the issue, including that by Associated Press, United Press International, the *Chicago Sun-Times,* the *Chicago Tribune,* the *State Journal Register,* and other major daily newspapers.

At this writing, a May 22 rally had been scheduled at the State Capitol. It's purpose: to impress upon legislators the seriousness of the malpractice crisis and the urgent need for reform. Physicians and other members of the medical family had the opportunity to talk with their own legislators and others. In May of 1976, 3,000 members of the medical community had a similar rally which was instrumental in passing previous malpractice reforms.

Membership Activity

Many physicians took advantage of clerical support provided by ISMS for a mass letter writing campaign during the Society's Annual Meeting, April 26-28. Hundreds of letters to legislators were generated, with carbon copies directed to local newspapers.

ISMS President Morgan M. Meyer, M.D., was keynote speaker at a mass meeting of 400 DuPage County physicians and local legislators. Each senator and representative from senate districts 19-23 and 25 was invited.

The hard work and persistence of physicians is beginning to pay off.



Alfred J. Clementi, M.D., Chairman, ISMS Board of Trustees, presents ISMS legislative package at April 11 press conference in Chicago.

Many legislators have commented that physician contact has been tremendous. Also, legislators have reported finding their physician constituents knowledgeable on all aspects of the issue and legislation.

Media Response

On the media front, radio and TV talk shows across the state have increasingly featured malpractice-related stories. Both local physicians and ISMS officers have been actively involved.

Drs. Allan L. Goslin and Fred Z. White of the Exchange Board of Governors faced Chicago plaintiff attorneys Barry Goldberg and Robert Clifford on the television program *AM Chicago,* hosted by Oprah Winfrey. The hour-long talk show sparked much controversy. In addition to the debate between the physicians and the lawyers, there was considerable audience participation, including that from patients who were plaintiffs and from defense attorneys.

Meetings with local editorial boards are a major component of the media effort. Action teams in southern Illinois have been especially active, with meetings already held with the *Quincy Herald Whig, Decatur Herald and Review, Mattoon Journal, St. Louis Globe-Democrat,* and *St. Louis Post-Dispatch.*

ISMS leadership, including Drs. Alfred J. Clementi, Robert C. Hamilton and Morgan M. Meyer, met with the *Chicago Sun Times* and *Chicago Tribune* to solicit their support for the legislation. Both papers had lent support to medical malpractice reform legislation in the past.

Other Contacts

Reaching the public and business groups has been a major concern of Drs. Goslin and White. Dr. White recently addressed the Ottawa Kiwanis Club, where local businessmen in the audience responded warmly. Dr. Goslin pursued support from public groups. He has recently addressed the Rockford Chamber of Commerce Legislative Committee and numerous Kiwanis and Rotary groups.

EKG

(Continued from page 349)

Answers: 1. B, C, E. 2. B, C, E.

This ECG is difficult because of the different QRS morphologies present as well as the baseline artifact. The arrhythmia caused the patient to become lightheaded and he had difficulty holding still. The simultaneous recording of leads in columns is helpful. The first beat in leads I, II, III is sinus conducted with a wide QRS, left axis deviation, and a normal PR interval. The second QRS in leads $V_1V_2V_3$ is also sinus with a wide QRS resembling complete right bundle branch block. The third beat in leads $V_4V_5V_6$ is again sinus with a wide QRS and prominent deep S waves of complete right bundle branch block. The last two beats of lead I, the last four beats of lead AVR, the last three beats of lead V_1, and the first two beats of V_4 represent a wide QRS tachycardia with a rate of approximately 150 beats per minute. There is slight irregularity of the RR cycles of the tachycardia as well as left axis deviation of its QRS complexes. A careful analysis of the P waves in this tracing as well as a longer multiple lead rhythm strip showed atrioventricular dissociation.

This is ventricular tachycardia. The patient was placed in the coronary care unit and a myocardial infarction was ruled out. Quinidine blood levels were drawn and found to be well within the therapeutic range. Therefore, quinidine was regarded as a drug failure since it did not control the ventricular tachycardia at therapeutic blood levels. The QT interval was prolonged to 0.56 seconds, best seen in lead V_1. Although the QT interval was prolonged, discontinuation of quinidine did not cause disappearance of the ventricular tachycardia. Therefore, quinidine did not seem to be a cause of the arrhythmias. Intravenous lidocaine controlled the tachycardia but no other available oral antiarrhythmic drug did. There was no evidence of heart failure or heart block, so digoxin, diuretics, or a pacemaker were not needed.

The patient's ventricular tachycardia was finally controlled with the experimental drug mexilitine at a dose of 400mg every eight hours. Mexilitine is a new orally active drug that resembles lidocaine in chemical structure. Since 1977, more than 10,000 patients who failed on other antiarrhythmic drugs have been treated with mexilitine, according to the manufacturer. ◀

Viewbox

(Continued from page 341)

Diagnosis: Osteoid Osteoma

Although all of the choices can present with somewhat similar radiographic findings, the patients' histories combined with the radiographs best fit with the diagnosis of osteoid osteoma.

A patient with an osteoid osteoma often has a characteristic type of bone pain. It is aching, localized, worse at night, not relieved by rest or heat but strikingly ameliorated by small doses of salicylates. When this history is combined with a radiograph showing a bone with an oval or round radiolucency (the nidus) surrounded by a zone of sclerosis, the diagnosis of an osteoid osteoma will be made in the majority of cases. Although a nidus was not seen in the radiographs shown, the reactive sclerosis along with the history and the age of the patients make osteoid osteoma the most likely diagnosis. Special radiographic techniques may be needed to visualize the nidus and will be discussed in subsequent sections.

Subacute osteomyelitis (Brodie's abscess) often develops in the distal femur or upper tibia. A Brodie's abscess may occasionally be accompanied by soft tissue swelling or even erythema while osteoid osteoma seldom produces these physical findings. The radiographic appearance of Brodie's abscess, however, can be similar to that of an osteoid osteoma. The abscess cavity often presents as a radiolucent area with a dense rim or faint surrounding density. This appearance is similar to a nidus, but most osteoid osteomas have a more striking dense sclerosis, which is unlike a Brodie's abscess. The lucency of a bone abscess is often irregular or, characteristically, serpiginous (Figure 4) in contrast to the oval or round nidus of an osteoid osteoma. Lastly, osteoid osteoma results in dense periosteal new bone. There is seldom periosteal new bone formation with Brodie's abscess.

Ewing's sarcoma is a malignant bone tumor that characteristically stimulates periosteal new bone in the shaft of a bone but the reaction is often a laminated "onion-peel" pattern rarely seen in an osteoid osteoma. In addition, fine patchy bone destruction common in Ewing's does not occur in an osteoid osteoma. A true nidus is not found in Ewing's sarcoma.



Figure 4
Lateral view of proximal tibia. This Brodie's abscess has a characteristic "serpiginous" lucency (arrows) surrounded by sclerosis. This type of central lucency does not occur in an osteoid osteoma. (Courtesy of Andrew Berkow, M.D. of Davenport, IA)

A fatigue-type stress fracture is most common in the distal portion of the shaft of the second, third, or fourth metatarsal but occurs in many other bones as well. These fractures are characterized by regional proliferation of cortical and medullary new bone which may be mistaken for an osteoid osteoma. Distinctions include: lack of a nidus, relief of pain by rest, and callus which increases over a duration of one to two weeks. This rapidity of change in the radiographic appearance and the alleviation of pain are not seen with an osteoid osteoma.

An eosinophilic granuloma is one of the histiocytic disorders. These lesions in bone are characterized by expanding, erosive accumulations of histiocytes within the medullary cavity. Any bone may be affected but favored sites are the calvarium, ribs, and femurs. Radiographically, an eosinophilic granuloma appears as a radiolucent defect secondary to bone destruction, which is almost always larger than the nidus of an osteoid osteoma. The defect in this lesion is not sharply delineated and does not contain calcification. It is distinctly unusual to see significant surrounding sclerosis, but periosteal reaction may be present.

Pathology

An osteoid osteoma is a benign bone neoplasm characterized by a small central nidus. When an osteoid osteoma is removed *en bloc,* the actual nidus is seen as a round or oval mass of tissue which is sharply delineated from the surrounding bone and can be lifted from its bed. It is usually reddish brown with a gritty, granular consistency.[1] The tumor consists of an area of variably calcified osteoid in a stroma of relatively loose vascular connective tissue with no polymorphonuclear infiltration. Surrounding this osteoid nidus is a zone of normal but sclerotic bone.[2] The osteoblasts in the region of the lesion are too well differentiated to be mistaken for osteogenic sarcoma. Malignant transformation does not occur.

The nature of the pain with osteoid osteoma has caused a great deal of interest. Abundant unmyelinated nerve fibers of the autonomic nervous system have been found accompanying blood vessels in the fibrous zone around the nidus and within the nidus. The pain may be mediated by these nerve fibers, presumably secondary to vascular pressure changes.[3]

Laboratory Studies

Laboratory studies in these patients are remarkable only in that they are normal. White blood cell count, hemoglobin, calcium, phosphorus, alkaline phosphatase, fibrinogen levels, sedimentation rate and all other values tested have been normal.[4]

Clinical (Table 1)

Osteoid osteoma is not rare. It has been shown to constitute up to 10% of all benign bone tumors. The entity has been described in every part of the skeleton except the clav-

Table 1*[5]
Osteoid Osteoma

Presenting Symptoms	
Pain	100%
Night Pain	94.7%
Bone Tenderness	62.1%
Arthralgia	18.0%
Myalgia	6.3%
Presenting Signs	
Bone Tenderness	62.1%
Muscle Atrophy	23.1%
Local Swelling	18.9%
Muscle Weakness	10.5%
Spinal Curvature	8.4%
Joint Swelling	5.2%
Sensory Changes	2.1%
Fever	2.1%

*Cohen, M.D., Harrington, T.M., Ginsburg, W.W.: "Osteoid Osteoma: 95 Cases and a Review of the Literature," *Seminars in Arthritis and Rheumatism* 12:3, 265-281, 1983. Reproduced by permission.

icle and sternum. In one series of 84 osteoid osteomas, a majority (56%) occurred in the diaphyses of the femur and tibia.[1] Other favored sites included the hand and foot (18%), humerus (7%), vertebrae (6%), ulna (3%), and ilium (3%). The remaining 10% arose in such sites as the rib, ischium, pubis, mandible, and patella.[1]

Osteoid osteoma occurs most commonly in children, adolescents, and young adults. Age distribution: under age 5 years, 7%; 5-25 years, 76%; over 35 years, 3%. The male:female ratio varies from 2:1 to 3:1. The primary complaint is pain which usually begins as dull, aching, and inconstant in nature. The pain increases in severity and may eventually become persistent. It is often described as "boring." The pain decreases with activity and increases at night. Although generally localized to the lesion, it may be referred to a nearby joint. Small doses of aspirin bring such effective relief that this response has become an important diagnostic feature. The history may be as long as two years but is rarely less than 6 months. Localized tenderness can often be elicited and there may be associated soft tissue swelling, particularly when the lesion is superficial.[2] Heat and erythema are conspicuously absent. Usually, the findings on physical examination are minimal. When present, findings are often related to the specific location of the lesion.

Osteoid osteomas located in or near a joint are unusual and are often difficult to diagnose. When in a peri-articular location, articular synovitis, monoarthritis, tenderness of the joint and juxta-articular osteoporosis may be present. Joint motion may be limited. Articular pain may be present long before the nidus becomes visible on radiographs. Bone scanning and CT may be of great use in these cases and will be discussed later.

Osteoid osteoma of the vertebrae is recognized with increasing frequency.[1] Diagnosis is difficult. Patients often undergo numerous radiographic studies before the correct diagnosis is reached. As in other areas of the skeleton, osteoid osteomas may produce pain before roentgenographic changes. These changes in the spine may be difficult to detect on plain films. In the vertebrae, 60% involve the lumbar spine, 30% the cervical spine, and 10% the thoracic spine.[1] Osteoid osteoma of the spine (Figure 3) is usually associated with painful scoliosis secondary to paravertebral muscle spasm. However, chronic scoliosis due to structural changes may also occur when there is a prolonged course prior to proper diagnosis.[5] The complaint of painful scoliosis is unusual in young people. The diagnosis of osteoid osteoma should be entertained when there is no history of significant antecedent trauma, no associated signs of inflammation, and the pain is strikingly relieved by aspirin.[7] Localized tenderness, restriction of motion, spasm of paravertebral muscles, an awkward gait, and radicular pain may be present. A head tilt or torticollis may accompany a lesion in the cervical spine. Neurological abnormalities are infrequent in patients with osteoid osteoma and spinal cord dysfunction is rare.[7] When neurological deficits are present they may be similar to those of severe neurologic disease and consist of sensory changes, radicular findings, muscle atrophy, and diminished or hyperactive deep tendon reflexes. Most vertebral osteoid osteomas are located in the lamina or pedicle. Less frequent locations include the articular facets, transverse and spinous processes. The vertebral body is a rare site for these lesions. Myelograms are usually normal and bone scanning as well as CT are often required to make the diagnosis.

Radiographic Findings

The classic roentgenographic appearance of an osteoid osteoma consists of an oval or round radiolucency, the nidus, surrounded by a wide zone of uniform density representing reactive sclerosis. The nidus has limited growth potential and rarely exceeds two centimeters in diameter. The associated bone formation varies with the location of the lesion and the age of the patient.[1] In the long bones, the most common sites are the diaphyses and metaphyses with the nidus near or within the periosteum.

Nidus—The nidus is most often radiolucent (50%) and usually not over 1cm in diameter (may be up to 2cm in diameter). However, it may be slightly or markedly calcified so that on radiographs it may be less dense, equally dense, or even more dense than the surrounding bone. Adequately or over-penetrated films or tomograms may be needed to visualize the nidus (Figure 5). The nidus may be located in the central region of the sclerosis but is usually the thickest part. Often a band of dense surrounding sclerosis obscures the nidus and is the only abnormality seen, particularly if adequate penetration hasn't been obtained. In rare instances the nidus is multifocal. Infrequently, a nidus may develop without any apparent alternation in the adjacent bone.

Reactive Sclerosis—The degree and extent of the sclerosis seem to vary with the location of the nidus and the patient's age. In the majority of cases a diaphyseal lesion incites abundant sclerotic reaction around most of the circumference of the nidus and extends several millimeters beyond it.[1] The reactive bone is often assymmetrical with respect to both the long axis of the shaft and the location of the nidus so that the nidus may be located toward the edge of the sclerosis and not in the center.[1]

Osteoid osteomas that originate

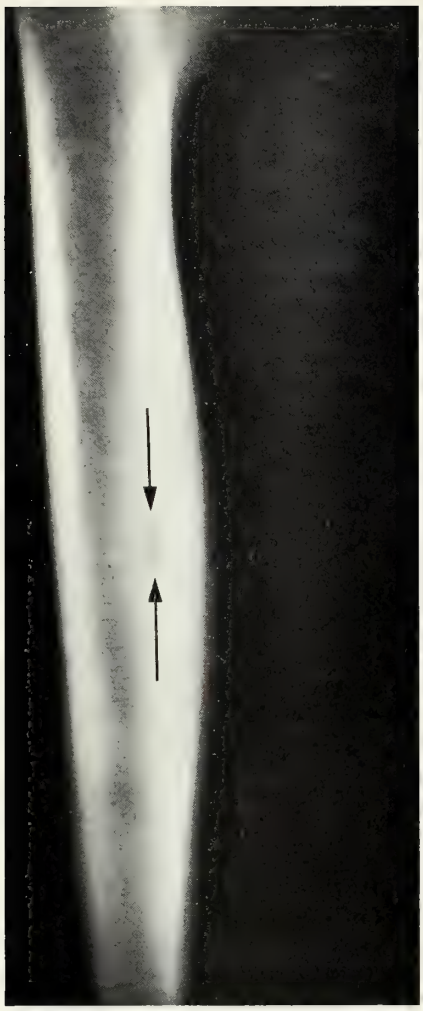


Figure 5
Tomogram of the osteoid osteoma in Figure 2. The nidus is now clearly visible as an oval lucency (arrows) eccentrically located in the lateral cortex of the femur which is thickened by reactive sclerosis.

in the cortex of the bone differ in appearance from those that arise in cancellous bone and from the rare subperiosteal osteoid osteoma. *Cortical* lesions (Figure 5) are the classic type of osteoid osteomas and consist of a small centrally located nidus, usually radiolucent, associated with dense reactive bone. In looking for a nidus, one concentrates on the portion with the greatest degree of bone change as well as its largest dimension. *Cancellous* osteoid osteomas (Figure 6) favor the neck of the femur, vertebral centra and the small bones of the hands and feet. This type of osteoid osteoma does not invoke surrounding reactive bone but often causes osteosclerosis at a point somewhat distant to the nidus. *Subperiosteal* osteoid osteomas appear as round soft tissue masses immediately adjacent to bone and occur most commonly at the inner aspect of the femoral neck and in the hands and feet. The underlying bone reveals pressure atrophy or irregular bone resorption.[3]

Other Imaging Methods

If radiographs fail to reveal the characteristic findings of an osteoid osteoma, other imaging methods can be used (Table 2). Because up to a third of the lesions have an atypical radiographic appearance, diagnostic delay may result. Also, in rare instances the history is atypical, *i.e.,* without a history of pain.

Angiography—The nidus of the osteoid osteoma is highly vascular. The angiogram demonstrates a small vessel with an irregular lumen supplying a highly vascular area in the bone. An intense circumscribed blush appears early in the arterial phase and persists into the venous phase. Histologic studies have shown the nidus to contain blood channels which explains this vascular blush.[1] Angiography has occasionally been used to differentiate the nidus of an osteoid osteoma from the lucent defect of a Brodie's abscess, which is avascular.

Bone Scintigraphy—An osteoid osteoma may escape detection if the history is atypical, the nidus is small or invisible, or the surrounding sclerosis minimal. The diagnosis is particularly difficult to make in the hip region, spine, and small bones of the hands and feet. In these cases a nuclear medicine study should be performed. Positive bone scans reflect a combination of osteoblastic activity and increased blood flow within or around lesions. Uptake is independent of the amount of mineralization.[3] This allows imaging of lesions which are invisible or barely seen on radiographs. The radiation dose from intravenous administration of technetium labeled compounds is small. The bone scan is extremely sensitive but non-specific. The osteoid osteoma is usually a well-circumscribed lesion which seems hyperemic in the early five minute blood pool image and shows an avid accumulation of radioisotope in the delayed scan (Figure 7).[9] If the bone scan is positive then tomograms may identify a nidus

Figure 6
Cancellous (medullary) osteoid osteoma. The nidus is located in the medullary canal rather than the cortex. The radiolucent nidus (N) is surrounded by only minimal reactive sclerosis (arrows).



Table 2*[8]

Plain Films

- Positive (66%) → Surgery
- Negative/Atypical → (+)Bone Scan(−)
 - Tomography (Long bones) → CT (Spine and Joints)
 - Observe

*Omojola, M.D., Cockshott, W.P., Beatty, E.G.: "Osteoid Osteoma: An Evaluation of Diagnostic Modalities," *Clinical Radiology* 32:199-204, 1981. Reproduced by permission.

which is not visible on radiographs.

Computed Tomography—CT can localize, confirm, and define the presence of a nidus with great accuracy. It is especially useful in examining the spine.[10] CT is also superior to conventional tomography in the demonstration of osteoid osteomas in cancellous bone due to higher contrast resolution.[11]

Computed tomography can also be helpful in directing the surgical approach. Dissection to provide exposure is minimized by pinpoint localization and complete removal of the nidus can be accomplished with less resection of surrounding normal bone.[10,12]

Treatment

Salicylates provide temporary relief in the majority of patients, but surgery is the definitive therapy. Removal of the nidus cures the disease. With excision of the lesion patients are completely and permanently relieved of their symptoms. The response is usually dramatic. Symptoms are usually relieved within a few days, sometimes within hours but occasionally not for as long as a month. If the nidus is completely removed there is no recurrence. If incompletely removed, symptoms persist or recur promptly and another operation is required.

In addition to making the diagnosis of osteoid osteoma, precise localization of the nidus is critical so that it can be easily identified and completely removed. Systems of localization vary; it is often sufficient to relate the nidus to an easily identifiable anatomic landmark. Opaque markers or guides such as needles can be inserted into nearby tissue (Figure 8). Drill holes for preliminary localization and filming of the piece of tissue to be removed can be performed. It is sound practice to make a radiograph of excised bone in order to be certain it contains the complete nidus.[1] It is noteworthy that some patients with typical clinical and radiographic findings of osteoid osteoma are cured following surgery yet no nidus is found in the tissue which was removed.[13]

Spontaneous cures have been reported in isolated cases. Radiation therapy has been used but has not been found to be effective.



Figure 7
Technetium 99m polyphosphate bone scan of the osteoid osteoma seen in Figure 1. Typical avid uptake of the radionuclide is demonstrated in the mid shaft of the right fibula.

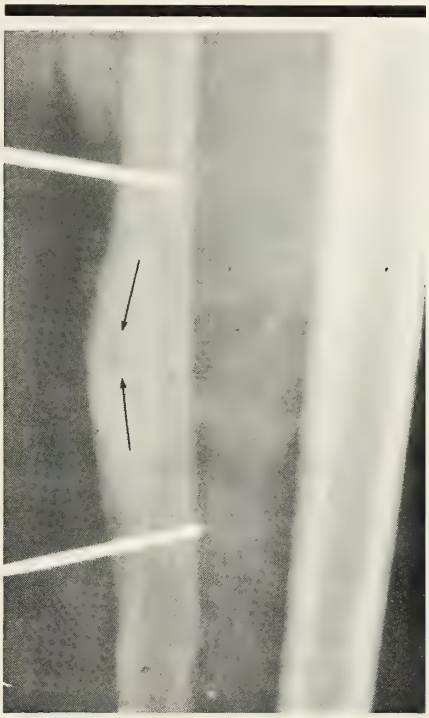


Figure 8
Osteoid osteoma: Pre-operative localization of lesion of fibula seen in Figure 1. Metallic drills superior and inferior to the lesion localize it prior to surgery. The radiolucent nidus seen here was not visible in Figure 1 because of differences in radiographic technique.

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PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

BLOOMINGTON:
Internal Medicine—To join an active six member IM practice in mid-western university community. A sub-specialty in Rheumatology, Endocrinology, or Allergy is desirable, but not necessary. Contact: J. Buchanan, The Health Center, 702 N. East St., Bloomington 61701 (309-827-5051). (2)

BRADFORD:
Family physician wanted to take over 32 years of well established rural practice with office and house—reason retirement. 120 bed equipped hospital 20 minutes drive, 35 miles from major medical and educational center. Elementary and high school 2 blocks from home. Contact (309) 897-8181. (6)

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Multi-specialty group thirty miles southwest of Chicago seeks board elegible obstetrician-gynecologist to join expanding practice. Incentive plan, profit-sharing, relatively new building. Excellent practice opportunity with above average grade and high schools. Contact Howard Osmus, Administrator, Hedges Clinic, Frankfort, Il. 60423. (815-469-2123) (2)

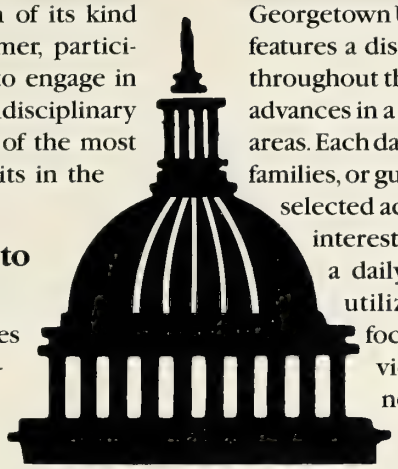
KANE COUNTY:
Experienced occupational health physician needed to direct medical porgram in manufacturing plant in Southwest Suburbs. Call regional medical director (312)981-2195. (4)

ROCK ISLAND:
Internist group looking for a fourth physician to join growing area of Illinois Quad Cities. General internist and/or internist with sub-specialty willing to practice some general internal medicine. Offering financial guarantees and free rent for first year. Contact: Greg Romans, 2701 17th Street, Rock Island, IL 61201. (3)

SAYBROOK
Family practitioner—Excellent opportunity in east central Illinois; large modern office available; rural setting near modern well equipped community hospital; community is within twenty minutes of major universities, tertiary care centers; metropolitan area with major shopping, recreational and cultural activities available; financial incentives possible. Contact William Stack (309) 475-3521. (3)

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Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

JUNE

Oncology

Controversies in Breast Cancer Treatment
For: Oncologists/Radiation Therapists/Surgeons/Family Practitioners. Course, June 12, 1985, Holiday Plaza Complex, Matteson, Illinois. **Sponsor:** The University of Chicago, 5841 S. Maryland Avenue, Box 139, Chicago, Illinois, 60637. **Fee:** $20. **Reg. Limit:** None. **Credit:** AAFP Elective: 6 hours; AMA Category 1: 6 hours. **Contact:** Marlene Goldberg, Conference Manager. **Phone:** 312/962-1056.

Obstetrics/Gynecology

Chicago Area Medical Schools Review Course in Obstetrics and Gynecology
For: Gynecologists. Course, June 10-15, 1985, Chicago, Illinois. **Sponsor:** The University of Chicago, 5841 South Maryland, Box 139, Chicago, Illinois, 60637. **Fee:** To be determined. **Credit:** Category 1: 32 hours; **Other:** ACOG: 32 hours. **Contact:** Mary Ann Dillon. Phone 312/962-1056.

Pathology

Flow Cytometry and Immunohistochemistry in Diagnosis of Hematologic Malfunction
For: Pathologists. Symposium, June 10, 1985, Drake Hotel, Chicago, Illinois. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Sponsor:** Chicago Pathology Society, Marshall H. Short, M.D., Loretto Hospital, 645 S. Central Avenue, Chicago, Illinois, 60644. **Co-Sponsor:** Michael Reese Hospital and Medical Center. **Contact:** Marshall H. Short, M.D. **Phone:** 312/626-4300, Ext. 5720.

Pharmacology

Prediction of Drug Levels and Drug Monitoring
For: Primary Care Practitioners. Conference, June 6-7, 1985, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut Street, Madison, Wisconsin, 53705. **Reg. Limit:** None. **Credit:** Category 1: 12 hours; **Other:** University of Wisconsin-Extension CEU's; AAFP Prescribed: TBD hours; AOA: TBD hours. **Co-Sponsor:** University of Wisconsin, School of Medicine, Department of Medicine; University of Wisconsin Hospital and Clinics. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** 608/263-2856.

Surgery

Medical and Surgical Review of Reflux Esophagitis and the Angelchik Prosthesis
For: Surgeons, Primary Care Physicians. Conference, June 14-15, 1985, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut Street, Madison, Wisconsin. **Fee:** $200. **Reg. Limit:** None. **Credit:** Category 1: 11 hours; **Other:** University of Wisconsin-Extension CEU's. **Co-Sponsor:** University of Wisconsin School of Medicine, Department of Surgery. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** 608/263-2856.

Peripheral Nerve Injury and Repair: The Practical Aspects
For: Surgeons. Lecture & Laboratory Workshop, June 27-29, 1985, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Fee:** $1000.00 **Reg. Limit:** 90. **Credit:** Category 1: 28 hours **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649 in Illinois, (800) 621-4651 outside Illinois.

Neoplasms of the Alimentary Tract: Current Concepts in Diagnosis and Therapy Symposium, June 14-15, 1985, Springfield, Illinois. June 14th—8:00AM-4:00PM, Sheraton Inn; June 15th—8:00AM-9:00AM, Memorial Medical Center. **Sponsor:** Springfield Clinic, 1025 S. Seventh Street, Springfield, IL. 62703. **Fee:** $25.00. **Reg. Limit:** None. **Credit:** Category 1: 9 hours. **Contact:** Betty Green, R.N., Springfield Clinic, 1025 S. Seventh St., Springfield, IL. 62703. **Phone:** (217) 528-7541.

Plastic Surgery

Practical Plastic Surgery
For: Physicians, other medical professionals. Symposium, June 4, 1985, 6:00PM-10:00PM, Alton, Illinois. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, Illinois 62708. **Fee:** $25.00. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** (217) 782-7711.

Genetics

Genetic Disorders
For: Physicians, other medical professionals. Symposium, June 13, 1985, 3:00PM-7:00PM, Quincy, Illinois. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, Illinois 62708. **Fee:** $25.00. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** (217) 782-7711.

Critical Care Medicine

Critical Care Medicine: A Review of Current Practice
For: Critical Care Physicians, Surgeons, Primary Care Physicians and Anesthesiologists. Lecture, June 10-15, 1985, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, Illinois 60612. **Fee:** $610.00. **Credit:** Category 1: 54 hours; **Other:** 54 Prep Credits. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649 in Illinois, (800) 621-4651 outside Illinois.

Relaxation/Fitness

Corporate and Industrial Wellness
For: M.D.'s, R.N.'s, O.T.'s, Exercise Leaders, Risk Management Personnel, Health Educators, Administrators, YMCA Personnel, Dietitians and Health Care Professionals. Workshop, June 10-13, 1985, La Crosse, Wisconsin. **Sponsor:** La Crosse Exercise Program Education Services Unit, Philip K. Wilson, Ed. D., La Crosse Exercise Program, Mitchell Hall, University of Wisconsin-La Crosse, La Crosse, Wisconsin, 54601. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; **Other:** 3.5 CEU's from Community Health, UW-La Crosse, Extended Education/UWEX; AAFP Prescribed: 35 hours. **Co-Sponsor:** La Crosse Lutheran Hospital/Gundersen Clinic, Ltd.

Teaching Stress Management and Relaxation Skills
For: M.D.'s, R.N.'s, P.T.'s O.T.'s, Exercise Leaders, Risk Management Personnel, Health Educators, YMCA Personnel, Administrators, Dietitians and other. Workshop, June 2-7, July 14-19, November 10-15, 1985, La Crosse, Wisconsin. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; **Other:** 3.5 CEU's from Community Health, UW-La Crosse, Extended Education/UWEX; AAFP Prescribed: 35 hours. **Sponsor:** La Crosse Exercise Program Education Services Unit, Room 221 Mitchell Hall, University of Wisconsin-La Crosse, La Crosse, Wisconsin, 54601. **Co-Sponsor:** La Crosse Lutheran Hospital/Gundersen Clinic, Ltd.

Fitness and Weight Control

For: M.D.'s, R.N.'s, P.T.'s, O.T.'s, Exercise Leaders, Risk Management Personnel, Health Educators, YMCA Personnel, Administrators, Dietitians and other Health Care Professionals. June 3-7, July 22-26, 1985. **Sponsor:** La Crosse Exercise Program Education Services Unit, Room 221 Mitchell Hall, University of Wisconsin-La Crosse, La Crosse, Wisconsin, 54601. **Fee:** $450. **Reg. Limit:** 40. **Credit:** Category 1: 35 hours; **Other:** 3.5 CEU's from Community Health, UW-La Crosse, Extended Education/UWEX; AAFP Prescribed: 35 hours. **Co-Sponsor:** La Crosse Lutheran Hospital/Gundersen Clinic, Ltd.

Orthopedics

Specialty Review in Orthopedic Surgery
For: Orthopedic Surgeons. Lecture, June 9-15, 1985, Chicago, Illinois. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL. 60612. **Fee:** $650.00. **Reg. Limit:** 90. **Credit:** Category 1: 68 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649 in Illinois, (800) 621-4651 outside Illinois.

Affective Disorders

Anxiety Disorders—1985 Update
For: Psychiatrists, Psychologists and Health Care Professionals. Lectures/Workshops, June 28-29, 1985, Wisconsin Center, Madison, Wisconsin. **Sponsors:** Anxiety Disorders Center, University of Wisconsin Department of Psychiatry and University of Wisconsin-Extension, Department of Continuing Medical Education. **Fees:** $200.00 for physicians and health care professionals; $100.00 for residents and trainees. **Credit:** AMA Category 1—10 hours; University of Wisconsin Continuing Education Units—1.0. **Contact:** Dorothy B. Davidson, Ph.D., Program Coordinator, Anxiety Disorders Center, Department of Psychiatry, University of Wisconsin Hospital and Clinics, 600 Highland Avenue, Madison, Wisconsin 53792. **Phone:** (608) 263-6129.

JULY

Emergency Medicine

Specialty Review in Emergency Medicine
For: Emergency Medicine Physicians. Lecture, July 29-August 3, 1985, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Fee:** $590 per person. **Reg. Limit:** None. **Credit:** Category 1: 45 hours; **Contact:** Robert J. Baker, M.D. **Phone:** (800)621-4649; (800) 621-4651 outside Illinois.

5th Annual Common Emergency Care Problems
For: Health Professionals Managing Emergency Problems. Conference with workshops, July 17-18, 1985, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg.; 610 Walnut Street, Madison, WI 53705. **Fee:** $225 for physicians, $150 for nurses and others. **Reg. Limit:** None. **Credit:** Category 1: 12 hours; University of Wisconsin CEU's; American College of Emergency Physicians—12 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Psychiatry
Special Marriage Enrichment
Symposium, July 13, 1985—1:00PM-6:00PM, Maywood, Illinois 60153. **Sponsor:** Loyola University Department of Psychiatry, 2160 South First Avenue, Room 3601, Maywood, IL. 60153. **Fee:** $30.00 per person. **Reg. Limit:** 60. **Credit:** Category 1: 5 hours; AAFP Elective: 5 hours. **Contact:** Domeena C. Renshaw, M.D. **Phone:** (312) 531-3752.

Dermatology
Practical Office Dermatology
For: Internists, Pediatricians, General and Family Practioners. Lecture, July 15-19, 1985, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Fee:** $500. **Reg. Limit:** 90 **Credit:** Category 1: 37 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649; (800) 621-4651 outside Illinois.

Obstetrics
High Risk Obstetrics
For: Obstetricians, OB-Gyne Residents and Fellows. Lecture, July 11-13, 1985, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago,IL 60612. **Fee:** $280. **Reg. Limit:** 90. **Credit:** Category 1: 21 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649. Outside Illinois: (800) 621-4651.

Pediatrics
Specialty Review in Pediatrics
For: Pediatricians. Lecture, July 22-28, 1985, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Fee:** $650. **Reg. Limit:** None. **Credit:** Category 1: 76 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649. Outside Illinois: (800) 621-4651.

Urology
Urologic Oncology
For: Urologists, Oncologists, Pathologists. Lecture, July 22-25, 1985, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Fee:** $470. **Reg. Limit:** None. **Credit:** Category 1: 32 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649, Outside Illinois: (800) 621-4651.

AUGUST

Surgery
Soft Tissue Surgery Workshop
For: MDs. Workshop, August 4-5, St. Louis, Missouri. **Sponsor:** Washington University School of Medicine, Office of CME, Box 8063, 660 S. Euclid, St. Louis 63110. **Fee:** $290. **Reg. Limit:** 60. Credit: Category 1, 14 hours; AAFP Prescribed, 14 hours. **Contact:** Loretta Giacoletto. **Phone:** 800-325-9862.

Specialty Review in General Surgery, Part II
For: Surgeons. Lecture, August 20-31, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $675. **Reg. Limit:** TBA. **Credit:** Category 1, 100 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600.

Fiberoptic Colonoscopy
For: MDs. Lecture, August 22-24, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. Limit:** 20. **Credit:** Category 1, 15 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600.

Fiberoptic Esophagogastric Endoscopy
For: MDs. Lecture, August 27-29, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, 60612. **Fee:** $450. **Reg. Limit:** 15. **Credit:** Category 1, 16 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600.

Radiology
Sixth Annual Cape Cod Summer Symposium on Ultrasound, CT, and MR
For: Radiologists, Technicians. Symposium, August 6-8, Hyannis, Massachusetts. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** $250 MDs; $175 Res., Tech. **Reg. Limit:** None. **Credit:** Category 1, 13 hours; UW-Extension CEU's, 13. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856

Internal Medicine
Specialty Review in Internal Medicine/Certifying
For: MDs. Lecture, August 5-11, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $510. **Reg. Limit:** TBA. **Credit:** Category 1, 72 hours. **Contact:** Robert J. Baker, M.D. **Phone:** 312-633-2600

Urology, Radiology
Endourology and Ureteroscopy: Triumphs and Pitfalls
For: Urologists, Radiologists. Lecture, August 3-4, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $450. **Reg. Limit:** 90. **Credit:** Category 1, 16 hours. **Contact:** Robert J. Baker. M.D. **Phone:** 312-633-2600

Clinical Medicine
National Symposium on Sexually Transmitted Disease
For: MDs. Symposium, August 10-12, Marriott's Lincolnshire Resort, Lincolnshire. **Sponsor:** Skokie Valley Hospital/Foundation, Program Office, 9600 Gross Point Rd., Skokie 60076. **Fee:** $295. **Reg. Limit:** 400. **Credit:** Category 1, 15 hours; AAFP Prescribed, 15 hours. **Contact:** Craig Olesen. **Phone:** 312-677-9600, Ext. 3354

Sports Medicine
Seventh Annual Sports Medicine Symposium
For: MDs, Sports Professionals. Symposium, Workshop, August 3-4, Waunakee, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg., 610 Walnut St., Madison 53705. **Fee:** TBA. **Reg. Limit:** None. **Credit:** Category 1, TBA; AOA, TBA; UW-Extension CEU's, TBA. **Contact:** Sarah Aslakson. **Phone:** 608-263-2856.

Medicine and Pathology
Lake County Liver and GI Clinico-Pathological Conferences
For: MDs. Lecture, August 28, 4:30-6:00pm, North Chicago. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Fee:** None. **Reg. Limit:** TBA. **Credit:** Category 1, 2 hours. **Contact:** Ben B. Blivaiss, Ph.D. **Phone:** 312-578-3215

1985 ICCME Congress

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DATE: October 11-12, 1985

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KEYNOTE SPEAKERS:

Robert K. Richards, Ph.D.
Assistant Dean and Associate Professor
Michigan State University, College of Human Medicine
Executive Vice President, Grand Rapids Area Medical Education Center,
Grand Rapids, Michigan.

Alan B. Knox, Ph.D.
Professor of Continuing and Vocational Education
University of Wisconsin, Madison, Wisconsin

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SORBITRATE®
(ISOSORBIDE DINITRATE)

Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks. Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites. Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established. If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE. The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy.

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary.

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur. Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory. The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined. However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals. On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months.

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers. In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal. The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly.

Information for Patients: Headache may occur during initial therapy with SORBITRATE. Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use.

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates

Isosorbide dinitrate acts directly on vascular smooth muscle; therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug. A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose. There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman.

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related. In clinical trials at various doses, the following have been observed.

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent. Cutaneous vasodilation with flushing may occur. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur. Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg; for oral (swallowed) tablets, 5 to 20 mg; and for controlled-release forms, 40 mg

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours. Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended. The extent to which development of tolerance should modify the dosage program has not been defined. *The oral controlled-release forms of isosorbide dinitrate should not be chewed*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg), Chewable Tablets (5, 10 mg), Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg).

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A Solid Start



Congratulations to all the citizens of Illinois on the extremely important beginning in solving the malpractice crisis in our state. The cumulative efforts of the ISMS membership, staff, auxilians, action team members, hospital people, non-member physicians and spouses, and of course the courageous and effective leadership of Representative Lee Daniels (R-Elmhurst), House Minority Leader, have culminated in an agreement in principle on the majority of items submitted in the ISMS legislative package on malpractice reform. We anxiously await the completion of the necessary legal language and the submission and passage of this whole agreement by the House and Senate and signature of Governor James Thompson.

The compromise agreement of the House and Senate leadership—Rep. Daniels, House Speaker Michael Madigan (D-Chicago); Senate Minority Leader James "Pate" Philip (R-Addison); and Senate President Philip Rock (D-Oak Park)—was reached moments before the official opening of the rally on the Capitol steps of some 4,000 physicians and friends at 2:45 p.m. Wednesday, May 22, 1985. The agreement was announced by Rep. Daniels and confirmed by Gov. Thompson, whose deputy, James Reilly had been facilitating the negotiations of the leadership over the past several weeks with increasing intensity for the few days immediately preceding the rally.

The substance of the agreement included all of the items of the ISMS package except for the "cap" on non-economic losses and the limitations on "wrongful death"—both of which are not included in the agreement. These items will undoubtedly have to be addressed at a subsequent legislative session.

It was, however, the efforts of physicians throughout the state that turned the tide. The rally was only the culmination of months of hard work—organizational activities at the hospital and county medical society level, meetings with legislators in their districts, countless telephone calls and letters to representatives and senators, meetings to enlist media support, appearances before civic groups, and other lay audiences, and, of course, discussions with patients. But we must not rest on our laurels. We must be vigilant and prepared to respond to any erosion of the terms of the May 22 agreement until the gavel comes down on this year's session of the General Assembly.

Our heartfelt thanks go out for the efforts to date by all the sponsors of our bills, and especially to Sen. Aldo DeAngelis, (R-Chicago Heights) and Rep. Alfred G. Ronan, (D-Chicago) for steadfast help throughout this long campaign. Special gratitude also goes to Rep. Sam Vinson, (R-Clinton) for his help on the floor management of the bills, and to the whole Republican minority membership for their overwhelming support of our efforts. A small group of Democratic majority members, including Chicago Representatives Ronan and Jesse White, Jr., and Senators Clarence Darrow, Rock Island, Jeremiah Joyce, Chicago, and William O'Daniel, Mount Vernon, were crucial to our success and helped greatly by standing up for our principles of fairness and balance.

Once again thanks to all, but especially to our marvelous ISMS staff from the secretaries to the lobbyists to the public relations people to Mr. Alexander Lerner, executive administrator, for his excellent leadership, planning, and direction of a task extremely well done.

Morgan M. Meyer

Morgan M. Meyer, M.D.
President



Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL® LA**
(PROPRANOLOL HCl) LONG ACTING CAPSULES



Ayerst®

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JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

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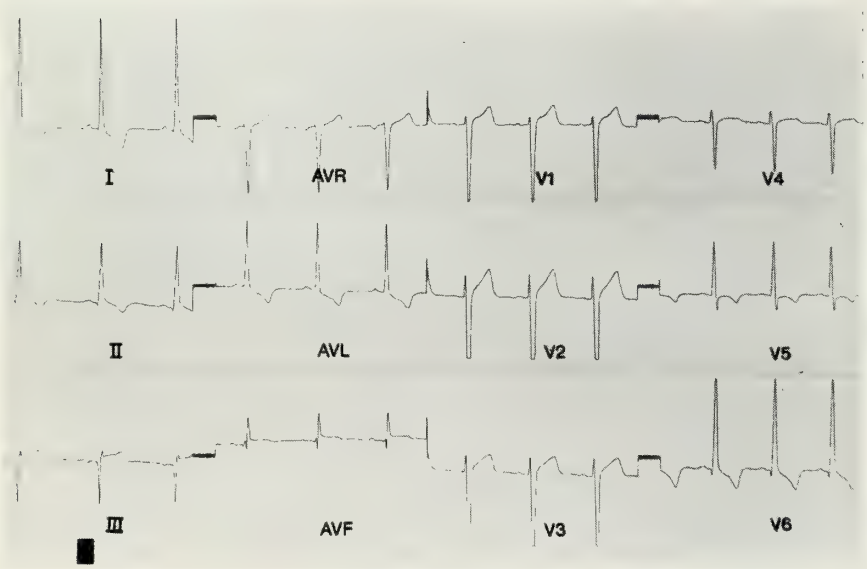
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EKG OF THE MONTH

CONTRIBUTING EDITOR JOHN F. MORAN, M.D., SECTION OF CARDIOLOGY, DEPARTMENT OF MEDICINE, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



This patient is a 32-year-old man with a one year history of worsening chest pain and dyspnea on exertion. The pain is located in the left precordium and is more easily caused by early morning exertion than exertion later in the day. The pain radiates into his neck and both arms. Over the past year, lesser activities have caused the chest pain. It will last up to 10 minutes and is always relieved by rest. Dyspnea on exertion is often associated with the chest pain and occasionally with diaphoresis. Over the past year, the frequency of these attacks has increased from once or twice a week to once daily. The patient denied lightheadedness, syncope, orthopnea, paroxysmal nocturnal dyspnea, and peripheral edema. The patient was aware that he had had a heart murmur since childhood. Two years ago, a routine chest x-ray had shown an enlarged heart. He has smoked one or two packages of cigarettes daily for the past 15 years.

Physical examination of the lungs was normal. Palpation of the precordium showed a systolic thrill at the right sternal border and the suprasternal notch. The first heart sound was normal but the second sound was single and diminished. There was a grade IV-V/VI crescendo systolic murmur heard all over the precordium which was loudest at the right sternal border of the base. At the lower left sternal border, a grade II/IV diastolic blow was heard. The rhythm was regular and no atrial or ventricular gallop sounds were heard. This twelve lead ECG was taken.

Questions:

1. **This twelve lead ECG shows:**
 a. Left anterior hemiblock.
 b. Complete left bundle branch block.
 c. Acute inferior wall myocardial infarction.
 d. Left ventricular hypertrophy with associated ST-T wave changes or the strain pattern.
 e. ST-T wave changes compatible with anterolateral ischemia.

2. **The following statement(s) is/are true:**
 a. This patient has a history of unstable angina.
 b. Cardiac catheterization and coronary angiography are indicated in this patient.
 c. The ECG represents an important adaptation to this disease.
 d. Angina is common in cases like this.
 e. All of the above.

(Continued on page 428)

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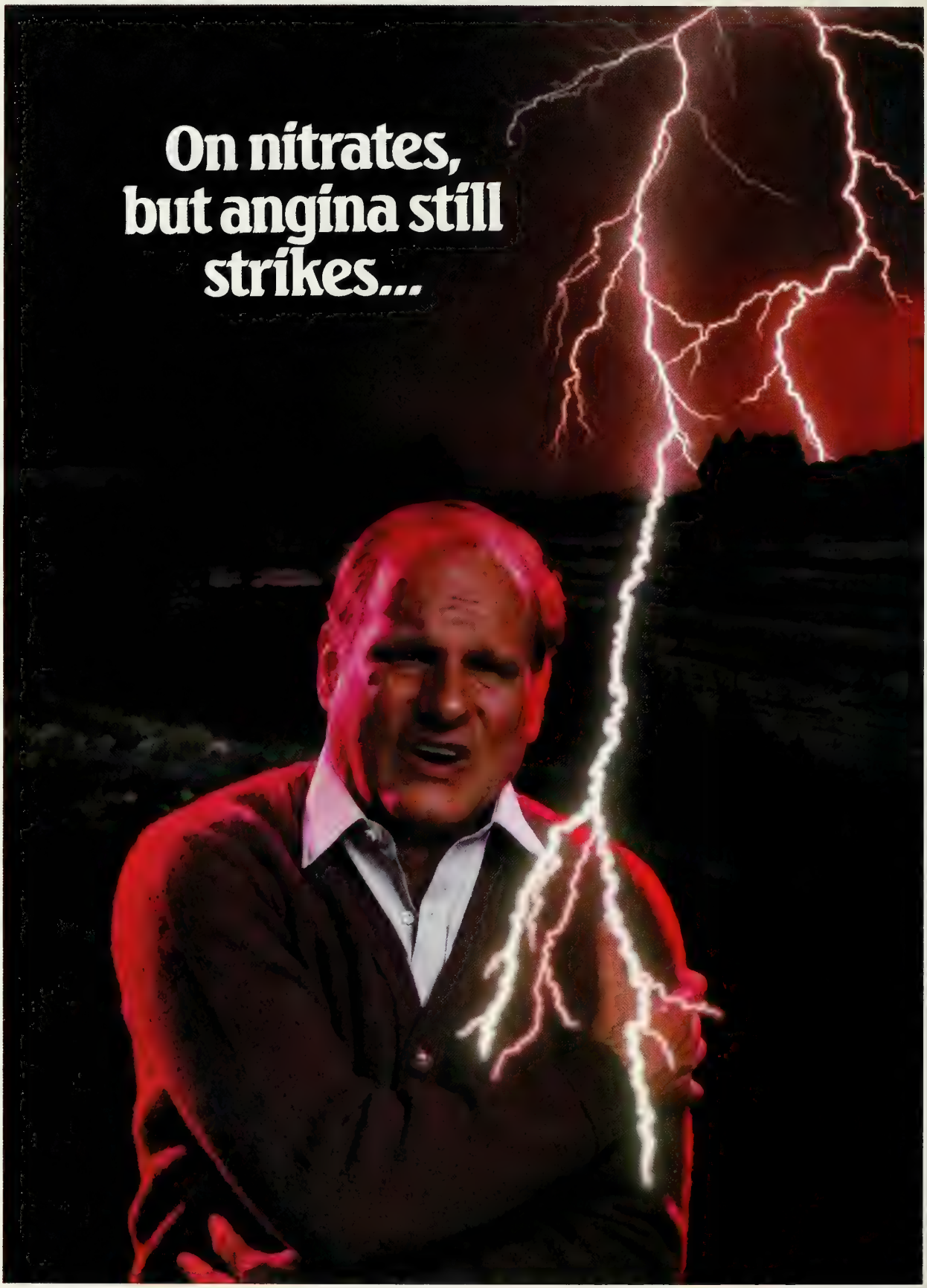
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but angina still
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After a nitrate, add ISOPTIN®
(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.



ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN®
(verapamil HCl/Knoll)
80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings),* hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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2406

MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P.,
CONTRIBUTING EDITOR

Pathological grasp reflexes were evaluated in 100 cases of unilateral hemispheric lesions. Thirteen of 45 patients with right hemispheric damage (29%) showed pathologic grasping in the right hand, the ipsilateral hand, whereas only two of 55 cases with left hemispheric lesions (2%) showed this grasp reflex in the left hand. The authors surmise possible causes to be right hand dominance and the greater tendencies in man to explore the right side of space. (Mori, E., Yamadori, A.: *Arch Neurol* 42:5,485-8, 1985)

Topical application of 4% lidocaine solution near the sphenopalatine fossa can abort many cases of cluster headache. Cocaine had been used for its sympathomimetic and anesthetic effects in experimental cluster headaches. The successful use of this anesthetic would indicate that the benefit to be derived is essentially anesthetic rather than sympathomimetic. (Kittrelle, J., *et al: Arch Neurol,* 42:5,496-8, 1985)

A recent study reports that (131)I-metaiodobenzylguanidine is an effective agent for diagnosis and localization of pheochromocytomas and paragangliomas. Five hundred uCi of (131)I-metaiodobenzylguanidine was administered intravenously to 48 patients. Scanning was positive in 20 cases with 77% sensitivity, 96% specificity, and 86% overall accuracy. It may be particularly useful in cases of suspected sporadic pheochromocytomas when the CT findings are normal. (Swensen, S., *et al: Mayo Clin Proc* 60:5,299-304, 1985)

The largest outbreak of measles recorded this year occurred at Principia College, a Christian Science college in Illinois. One hundred twenty eight cases (113 students and 15 among other local residents) are reported among 712 students enrolled. The source of the outbreak is still unknown. Previous outbreaks were reported in Ohio and Massachusetts. (*Morbidity and Mortality Weekly Report,* 34:9,10, 1985)

Increased vascular permeability is an important cause of the lowered concentration of albumin seen in acute and chronic disease. The rate of loss of albumin to the tissue spaces is usually at the rate of 5% per hour, which is 10 times greater than synthesis and catabolism. In septic shock the transcapillary escape rate rose 300% and seven hours after cardiac surgery the escape rate rose 100%. In cachectic cancer patients the escape rate was twice the rate of healthy patients. (Fleck, A., *et al: The Lancet* 8432:781-3, 1985)

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Tranxene dramatically increased beta wave activity

- relieved anxiety
- maintained alertness

In a double-blind randomized study of 20 patients with generalized anxiety disorder, patients treated with Tranxene showed marked improvement in Hamilton Anxiety Ratings, and dramatic increase in beta wave activity. Increased beta wave activity was correlated with improvement on the intellectual item (difficulty in concentration, poor memory) of the Hamilton Anxiety Rating Scale.[1]

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*Problem sedation is defined as moderate to severe degrees of sedation, sleepiness, drowsiness, or lassitude.

For further details of this study, contact your Abbott representative.

Please see next page for Brief Summary.

TRANXENE®
(clorazepate dipotassium) CIV

Brief Summary of Prescribing Information

INDICATIONS—For management of anxiety disorders or short-term relief of symptoms of anxiety; for symptomatic relief of acute alcohol withdrawal; for adjunctive therapy in partial seizures

Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic. Effectiveness in long-term management of anxiety (over 4 months) not assessed by systematic clinical studies. The physician should periodically reassess usefulness for each patient

CONTRAINDICATIONS—Known hypersensitivity to the drug. Acute narrow angle glaucoma

WARNINGS—Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

Pregnancy and Lactation: Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers

PRECAUTIONS—Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated

ADVERSE REACTIONS—Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure

INTERACTIONS—Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE

OVERDOSAGE—Take general measures as for any CNS depressant

SUPPLIED—TRANXENE 3.75, 7.5, and 15 mg capsules and scored tablets. TRANXENE-SD Half Strength 11.25 and TRANXENE-SD 22.5 mg single dose tablets.

REFERENCES:

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5. Dureman I, Norrman B: Clinical and experimental comparison of diazepam, clorazepate and placebo. *Psychopharmacologia (Berlin)* 40:279-284, 1975.
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8. Dureman I, Malmgren H, Norrman B: Comparison studies of chlorazepate administered as a divided daily dose and as a single dose at night. *Psychopharmacology* 57:123-126, 1978

Abbott Pharmaceuticals, Inc.
North Chicago, IL 60064

EKG

(Continued from page 422)

Answers: 1.D 2.E

This patient's ECG shows left ventricular hypertrophy with associated ST-T wave changes or the strain pattern. The PR, QRS, and Q-T intervals are normal and the QRS axis is approximately +15° in the limb leads. These measurements rule out conduction defects. The Q wave in lead III is not accompanied by significant Q waves in leads II or AVF and thus is not significant itself. The ST segment elevation present in leads III and AVF is the reciprocal of the ST segment depression seen in leads I and AVL; all caused by left ventricular hypertrophy. In the leads reflecting the left ventricle, the ST segment and the T wave are in an opposite direction to the QRS. These are the ST-T waves of "ventricular strain." In the absence of voltage criteria for left ventricular hypertrophy, these ST-T wave changes could be compatible with ischemia. However, many QRS voltage criteria for left ventricular hypertrophy are present here: the Lewis index (R_I-R_{III}) +(S_{III}-S_I) > 17, $SV_1 + RV_5$ or $RV_6 > 35$, $R^{AVL} > 13$.

This patient's history is one of a worsening or unstable angina pectoris. His physical examination suggests aortic stenosis and regurgitation. Left ventricular hypertrophy with the strain pattern on the ECG can be present in up to 85% of these patients. The left ventricular cardiac output is maintained by the development of left ventricular hypertrophy. The obstruction of aortic stenosis can be slowly progressive. Asymptomatic patients with aortic stenosis can have a good prognosis, especially with a normal ECG. However, once any of the cardinal symptoms of angina pectoris, syncope, or congestive heart failure develop, the prognosis is poor.

Angina can be present in as many as two-thirds of these patients but only half of these will have coronary artery disease. Cardiac catheterization and coronary angiography are indicated here. Our patient had severe calcific aortic stenosis, mild aortic regurgitation, and normal coronary arteries.

Many attempts have been made to estimate the aortic valve gradient from analysis of the ECG. An interesting method has recently been reported by Siegel and Roberts.[1] They found that the sum of the total twelve lead QRS amplitudes in millimeters correlates well with the peak left ventricular systolic pressure in mmHg. Therefore, you could subtract the systemic systolic blood pressure from this sum of the QRS amplitudes and get an estimate of the aortic valve gradient. The sum of the patient's QRS amplitude is 248mm. If we subtract 140mmHg as the systemic systolic blood pressure, the aortic valve gradient would be 108mmHg in our patient. This compared favorably to a gradient of 100mmHg. It did not apply to cases with bundle branch block. Readers should test this observation in their own aortic stenosis patients.

Reference

1. Siegel, R.J., Roberts, W.C.: *American Heart Journal,* 103:201-221, February, 1982.

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Physicians Storm Capitol Demanding Malpractice Reform

More than 4,000 physicians and their supporters rallying at the door of the State Capitol on May 22 had something to cheer about when terms of an agreement among key legislative leaders and the Governor on the issue of malpractice reform were announced.

Carrying banners, signs and makeshift placards, physicians had traveled to Springfield by the busload to confront legislators in their offices and outside the doors of the House and Senate chambers in a massive lobbying effort that seasoned observers said "made the difference" in breaking the legislative logjam on malpractice. An Illinois State Medical Society negotiating team worked around the clock before the rally, finally coming to an agreement literally minutes before the rallyers converged on the steps and front lawn of the Capitol in a show of support for the ISMS proposals. Subsequent to this agreement, further discussions took place among legislative leaders and several technical modifications were made in some aspects of the original agreement.

The package of bills agreed upon included 10 of the 12 ISMS proposals, including:

Verdicts of more than $250,000 would be structured to be paid in increments. A plaintiff could receive a lump sum of $250,000 or up to 50% of future damages immediately for cause shown, and payment could continue after the death of a plaintiff, according to the actuarial projection of life.

The "special damages" provision pertaining to counterclaims would be abolished, making it easier for physicians victimized by frivolous malpractice suits to countersue. Awards of attorney fees against a plaintiff would be permitted when untrue allegations are made without probable cause.

Punitive damages in medical and legal malpractice cases would be abolished.

Limits would be placed on attorney contingency fees in medical malpractice cases (33.3% of the first $150,000; 25% of the next $850,000; and 20% of any award over $1 million).

Three-member (judge, attorney, physician) screening panels would be created to screen claims for merit prior to filing of a suit. Parties (plaintiff or defendant) proceeding against a decision of the panel, and who fare no better, would pay the other party's costs.

Jury verdicts would have to be itemized to force calculation of awards based upon the actual economic needs of the patient.

An affidavit of an attorney would be required to indicate that consultation had taken place with a physician who believed a meritorious case exists. At the conclusion of a case, permission for recovery of attorney fees could be made against a plaintiff if untrue allegations were made.

Verdicts would be reduced by any amount received from "collateral" sources such as medical insurance, although reductions could be no more than 50% of a judgment.

Expert medical witnesses would have to be licensed in the same specialty as a defendant. The court would decide whether a witness devoted an appropriate portion of time in practice, research or teaching to that specialty.

Defendants uninvolved in the case could be dismissed early via filing of a simple affidavit.

Other provisions contained in the agreement would require release of patient records within 60 days of a request and increased reporting by insurance companies

of financial information. A final provision allows the Medical Disciplinary Board, during investigation of a physician's competence and potential violation of the Medical Disciplinary Act, to compel the physician to submit to a mental or physical examination.

Legislative leaders have agreed to work for swift consideration and passage of the agreement and move the legislation to the Governor's desk for his signature. Governor Thompson has agreed to sign the legislation immediately. If all proceeds as expected, the bills would become law August 15, 1985.

Legislative leaders also agreed to work for passage of a bill that would provide immunity for doctors and hospitals which revoke, suspend or otherwise limit medical staff privileges of incompetent or impaired physicians and also to work toward creation of a special segregated Cook County court calendar for consideration of medical malpractice lawsuits.

Physicians were unable to gain a $300,000 limit on awards for "pain and suffering" and other non-economic concerns. They also were unsuccessful in attempting to include another provision that would have set a presumed limit on "wrongful death" claims of $25,000. But ISMS leaders and legislative sponsors vowed to return to Springfield to fight for some kind of cap on malpractice awards.

The agreement by legislative leaders represented a sound rebuff to plaintiff attorneys anxious to preserve the status quo. Earlier in the legislative session, trial attorneys began to concede that physicians had a legitimate concern about the number of frivolous suits being filed. However, the attorneys, represented by the Illinois Trial Lawyers Association, refused to support far-reaching reforms that the medical community believed necessary to bring physicians some relief from ever-rising malpractice insurance premiums.

Complaining that they had fallen victim to a "well-oiled, well-organized" effort by ISMS, attorneys were quick to criticize announcement of the agreement. Press reports quoted Chicago Bar Association President John D. Hayes saying that "there is no agreement to which the Chicago Bar Association is a party." Echoing those comments was Jon DeMoss, president of the Illinois State Bar Association.

In announcing the legislative agreement, ISMS President Dr. Morgan M. Meyer praised the work of House Minority Leader Lee Daniels (R-Elmhurst) for "strongly advocating the physicians' point of view in negotiations with other legislative leaders." Dr. Meyer also had praise for Senate Minority Leader James "Pate" Philip (R-Addison) for generating support for the package in the Senate. Primary sponsors of the legislation, Sen. Aldo DeAngelis (R-Chicago Heights) and Rep. Alfred G. Ronan (D-Chicago) were commended for aggressively managing the legislation to position it for passage.

Dr. Meyer, ISMS Board of Trustees Chairman Dr. Alfred Clementi, Past President Dr. Robert C. Hamilton and other ISMS leaders pointed to the Springfield rally as the "culmination" of nearly two years of work.

"What made the difference," said Dr. Meyer, "was the work of individual hospital medical staffs and county medical societies who put continuous pressure on their own legislators to support this important package of legislation." Action teams had been organized in hospitals and county societies to coordinate legislative, public, and media support for the ISMS malpractice initiative.

Until the last moments prior to the agreement, physicians had been working at a fever pitch to gain approval of reform legislation. The bulk of that work in the weeks before agreement centered around telephone contact with legislators and meetings with editorial boards of newspapers and broadcast media.

Early in May, all action team members and countless other physicians were contacted by ISMS representatives who asked them to call their representatives in support of a motion to overturn a House Judiciary Committee decision to bottle up the ISMS-sponsored legislation. The intense pressure on legislators resulted in 115-0 vote to approve one of the bills, H.B. 1604, for consideration by the entire House. Reports from legislators indicated that no legislator received less than 40 calls, and one reported as many as 400 calls from concerned physicians and patients.

The massive telephone effort was repeated later to encourage the House to add amendments to H.B. 1604 incorporating all the ISMS proposals and to urge the Senate to take similar action with respect to S.B. 1031. Although the House effort fell a few votes short of passage, impetus was provided for the negotiating sessions that spawned the May 22 agreement.

Attempts to gain media support were an integral part of the legislative effort. Action team members in Joliet, Alton, Bloomington and Dixon—to name a few—presented the issue and the medical community's solutions to editoral boards. Dr. Meyer appeared on WMAQ-TV in Chicago to rebut an editorial endorsing the watered-down counter-proposal offered by the trial lawyers.

Other physicians meeting with editorial writers included Dr. Clementi, who visited Paddock Papers; and Dr. Earl Frederick, who met with the *Chicago Defender.*

In addition, "Everybody's Problem," the 22-minute documentary produced by ISMS and the Illinois State Medical Inter-Insurance Exchange, was made available for use by hospitals, county medical societies and cable television outlets to help educate the public about the seriousness of the malpractice problem. Copies of the tape are available in VHS, Beta and Sony U-Matic formats. Contact ISMS at (312) 782-1654 for further information. ◂

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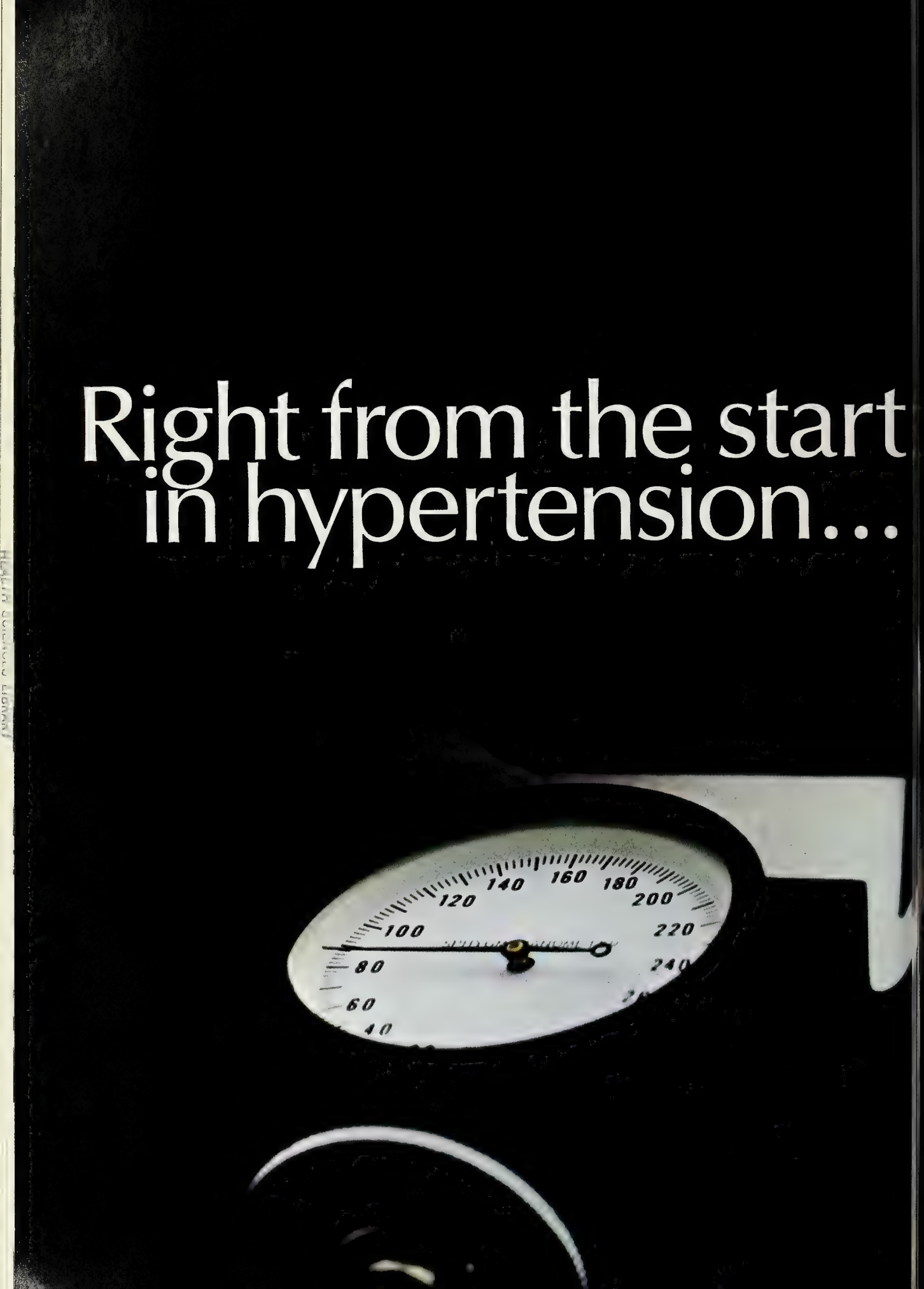
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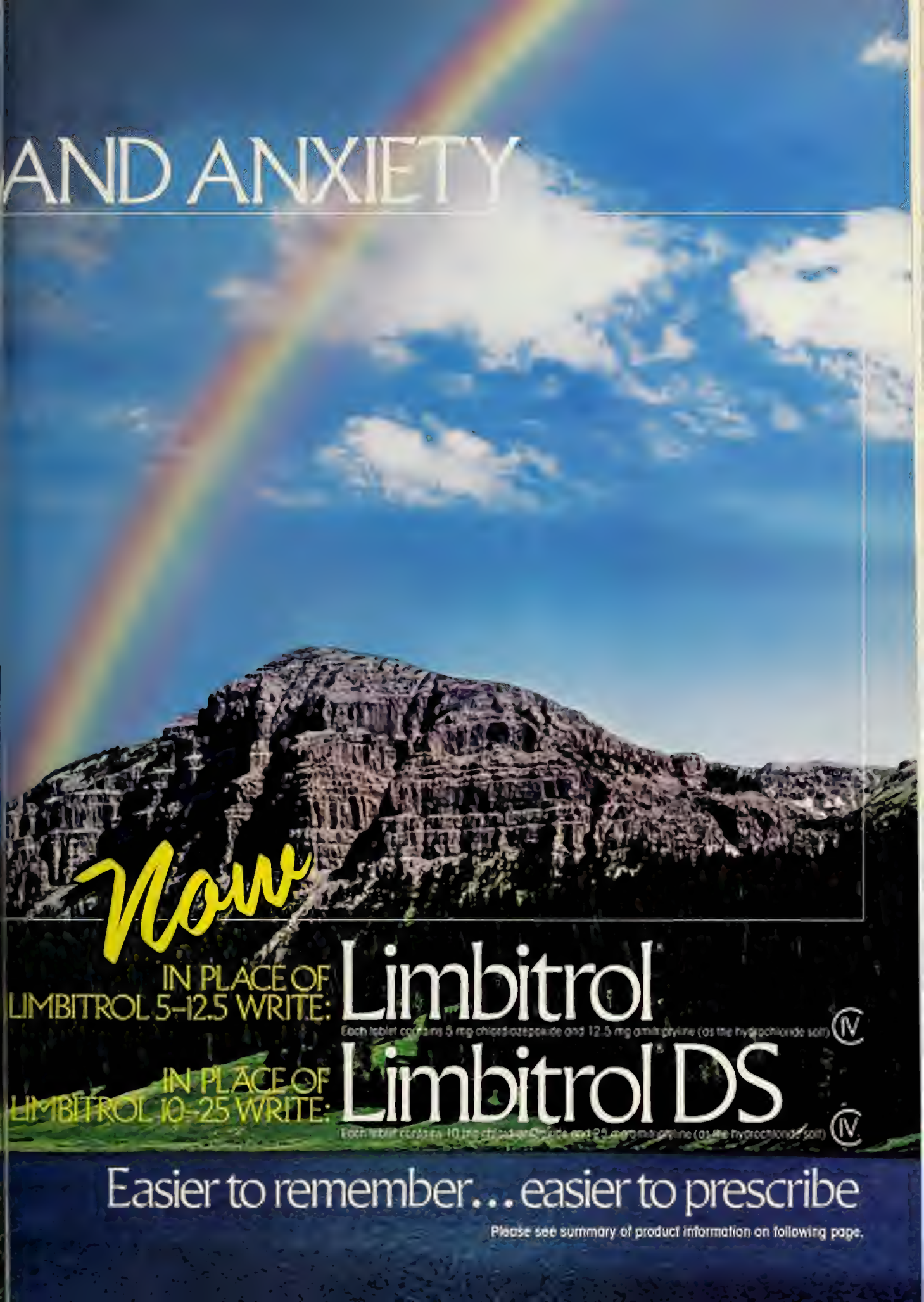
Please see brief summary of prescribing information on the next page for further details.

In moderate depression and anxiety

CLEARING: BOTH DEPRESSION...



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Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
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Please see summary of product information on following page.

LIMBITROL® (IV) Tranquilizer-Antidepressant

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use, then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).
***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.
Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: *Double strength (DS) Tablets*, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets*, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500, Tel-E-Dose® packages of 100; Prescription Paks of 50.

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AMA Introduces PRO Monitoring Project

The American Medical Association has announced an innovative new program to evaluate physician and hospital experience with Peer Review Organizations (PROs) set up to monitor health care delivered to Medicare beneficiaries. Under the PRO program, both utilization and quality issues will be examined by state level PROs under contract to the federal government. A percentage of all Medicare discharges will be reviewed with respect to quality and utilization objectives. These are objectives under contractual agreement between each PRO and the Health Care Financing Administration (HCFA).

The AMA is interested in learning of positive and negative individual physician and hospital experiences, which can be attributed to the new peer review system. While the AMA is interested in all relevant experiences, areas of particular interest would include: changes in length of stay, admission and discharge policies, preadmission certification procedures, utilization and quality review results, administrative relations between hospitals and physicians and the PROs, any demonstrable impact that PRO review may have on the cost or quality of care, and the results of any PRO efforts to review patients other than Medicare beneficiaries.

Physicians or hospital medical staffs who would like to share this information with the AMA are encouraged to describe their experience(s) in a brief letter and direct it to: AMA PRO Monitoring Project, Department of Health Care Financing & Organization, American Medical Association, Post Office Box 10947, Chicago, Illinois 60610.

All sources of information provided will be kept confidential. Data will be carefully analyzed and utilized as the AMA pursues further involvement with PROs and develops new ways to assist physicians and medical staffs in this area. ◀

Angina comes in many forms...

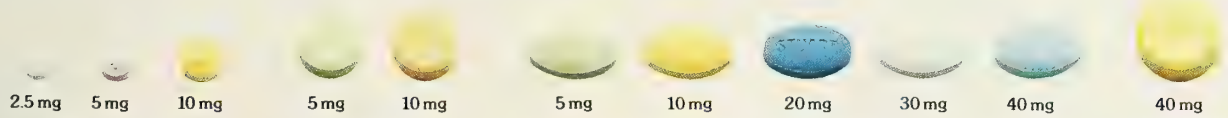


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See following page for brief summary of prescribing information.

SORBITRATE®
(ISOSORBIDE DINITRATE)

Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks. Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis.

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites. Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established. If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension.

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE. The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy.

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary.

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur. Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory. The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined. However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals. On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months.

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers. In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal. The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly.

Information for Patients: Headache may occur during initial therapy with SORBITRATE. Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use.

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates.

Isosorbide dinitrate acts directly on vascular smooth muscle; therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug. A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet.

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose. There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman.

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established.

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related. In clinical trials at various doses, the following have been observed:

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent. Cutaneous vasodilation with flushing may occur. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur. Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg; for oral (swallowed) tablets, 5 to 20 mg; and for controlled-release forms, 40 mg.

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose. In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure.

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours. Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported.

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended. The extent to which development of tolerance should modify the dosage program has not been defined. *The oral controlled-release forms of isosorbide dinitrate should not be chewed.*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg); Chewable Tablets (5, 10 mg); Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg).

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ABSTRACTS OF ACTIONS

January 12, 1985

ISMS Conference Complex

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

PROFESSIONAL LIABILITY INITIATIVE DOCUMENTARY

A new public education videotape entitled, "Everybody's Problem" was viewed by the Board and members of the House of Delegates during the 1985 Annual Meeting. The videotape focuses on the effect the malpractice crisis is having upon the public from both a cost standpoint and a limitation of availability of medical services. The Board approved the videotape which will be produced in multiple copies and available for local cable TV, closed hospital TV and other appropriate uses.

PREFERRED PROVIDER ORGANIZATIONS (PPO) LEGISLATION

The Board, at its January 12, 1985, meeting, agreed to endorse and cause to be introduced, proposed PPO legislation. After review, the Board agreed to endorse the proposed PPO legislation with the inclusion of the following elements: (1) That language identifying any willing provider be replaced by language reflecting "any willing non-institutional provider"; (2) Prohibit "most favored nation clauses" (a mandate that any provider charge only the lowest rate of all payors); (3) Prohibit "illusionary choice" (by contracts that provide only token payments to non-preferred providers); and (4) Allow PPOs the option of becoming risk-bearing entities.

NOMINATIONS, ELECTIONS, APPOINTMENTS

Acting on recommendations of the Councils and Executive Committee, the Board:

- Elected Dr. Alfred J. Clementi, Arlington Heights, as chairman.
- Appointed Dr. Cyril C. Wiggishoff, as Finance Committee chairman and Dr. Alfred J. Kiessel, as Policy Committee chairman.
- Nominated Drs. Phillip Boren, Alfred Clementi, Robert Hamilton, Jerry Ingalls, Clifton Reeder and Warren Tuttle, for the ISMIS Board of Directors.
- Appointed Dr. Alfred J. Clementi as proxy for the shareholder, Illinois State Medical Society, at the annual meeting of ISMIS May 15, 1985, to cast the proxy vote for Directors of ISMIS.
- Nominated Dr. Henrietta Herbolsheimer for the AMA Benjamin Rush Award for Citizenship and Community Services.
- Nominated Dr. Peter Friedell, Chicago, for reappointment as ISMS representative to the Board of the Illinois Cancer Council.
- Nominated Dr. Joseph Daddino, Chicago, for appointment to the Ad Hoc Committee on Substance Abuse Education.
- Nominated Dr. Dean Bordeaux, Peoria, for appointment to the IDPH Family Practice Residency Program.
- Nominated Dr. Patrick Staunton, Oak Park, as ISMS/IPS Liaison to the Department of Mental Health & Developmental Disabilities' Psychiatric Advisory Council.
- Nominated Dr. John Holland, Springfield, for reappointment as a representative of Project Medical Directors on the Emergency Medical Services Council, Department of Public Health.
- Approved a roster of physician nominees for AMA Residency Review Committees for input and approval of the AMA Delegation and forwarding to the AMA.
- Nominated Dr. Tamara T. Mitchell, Urbana, for appointment to the IDPH Medical Determinations Board.
- Nominated Drs. Richard Banta, Rockford; Violet Eggert, Tinley Park; Lee Gladstone, Chicago; Sydney Schnoll, Chicago, and Edward Senay, Chicago, for appointment to the Medical Advisory Committee, Illinois Department of Alcoholism and Substance Abuse.
- Nominated Dr. Thomas John, Burr Ridge, to serve on the State Medical Advisory Committee of the Illinois Department of Public Aid.

AIDS

The Board agreed to: (1) Not support the action of the Department of Public Health which prohibits Illinois blood banks from releasing the results of the AIDS screening test to blood donors; (2) Request that IDPH provide this test for those who want it without having to donate blood; (3) Discourage physicians from offering the HTLV-III antibody test to their patients as a diagnostic test for AIDS, as it is intended solely as a screening test for the safety of blood; and (4) Have ISMS provide, upon request, information to members about the HTLV-III antibody test and the appropriate counseling and treatment of patients suspected or known to have AIDS or the HTLV-III virus.

COMMITTEE ON DRUGS AND THERAPEUTICS

The Board approved the following drug products for inclusion in the IDPA Drug Manual: DDAVP Nasal Solution; Opticrom 4% Ophthalmic Solution; Roxanol SR Tablets; MS Contin Tablets; Fioricet Tablets and Capsules; Capoten 12.5mg Tablets (New Dosage Form); Depakote 12.5mg Enteric Coated Tablets (New Dosage Form); Triamcinolone Cream, Ointment and Aminocaproic Acid.

The Board also recommended that the following drugs not be included in the IDPA Drug Manual: Stadol Injection; Combi-Pres 3 Tablets; Tenoretic Tablets; Urocit Tablets; Tornalate Inhaler Aerosol and Unifiber.

The Board further recommended that Combi-Pres 1 and Combi-Pres 2 Tablets be removed from the Drug Manual.

OTHER ACTIONS

In addressing various other issues, the Board:

- Ratified the settlement accomplished in the Wilk litigation.
- Reviewed legal counsel recommendations regarding professional negotiations and directed that "voluntary health care services contracting" legislation be developed for introduction in the General Assembly.
- Accepted the 1984 Audited Financial Statement; March 31, 1985, IMPAC Collection Data; March 31, 1985, Dues Payment Report; and Requests for Changes in Membership Status.
- Approved a revised physician statement (pledge) to patients regarding support for the Professional Liability Initiative.
- Agreed to oppose the IHA proposal to eliminate due process elements from medical staff bylaws.
- Approved three late resolutions for introduction to the 1985 House of Delegates, entitled, "Duties of the ISMS Board of Trustees' Executive Committee in Regard to the Illinois Council on Continuing Medical Education," "Hospital Clinical Training Program," and "Driving Under the Influence of Alcohol."
- Approved Auxiliary requests to: (1) Co-sponsor and fund $7,000 to the ISMS Auxiliary from the ISMS Educational and Scientific Foundation, Inc., for the purpose of establishing a program to address the problem of teen suicide through educational and informational means; and (2) Co-sponsor a project to print personal medical identification cards for senior citizens. The Auxiliary would print the first 100,000. If a second printing is necessary the Auxiliary asks ISMS to contribute $700 for printing costs.
- Approved the development of local programs to disseminate information on and encourage the use of the "Guidelines for Physician-Attorney Relationships."
- Referred the funding of graduate medical education programs to the Executive Committee for review and consideration with report back to the Board.
- Approved the final development and promotion of the ISMS Physicians Games.
- Approved the design and implementation of the plans for the Substance Abuse Education Program for 1985-86, contingent upon the funding for each item by the Department of Alcoholism and Substance Abuse.
- Approved adoption of an amendment to the Protocol for the Recognition of State Medical Societies which provided for a change in the types of recognition issued by ACCME. The Board also agreed to advise the ACCME of its decision.
- Agreed to submit to the ISMS House of Delegates at the 1985 Annual Meeting a resolution amending ISMS Bylaws to create a Section on Hospital Medical Staffs.
- Adopted positions recommended by the Governmental Affairs Council on a list of bills pending in the General Assembly.
- Referred a request that the paragraph in the statutes in regard to reciprocity be deleted from the Medical Practice Act, to the Council on Education and Manpower for review and report.

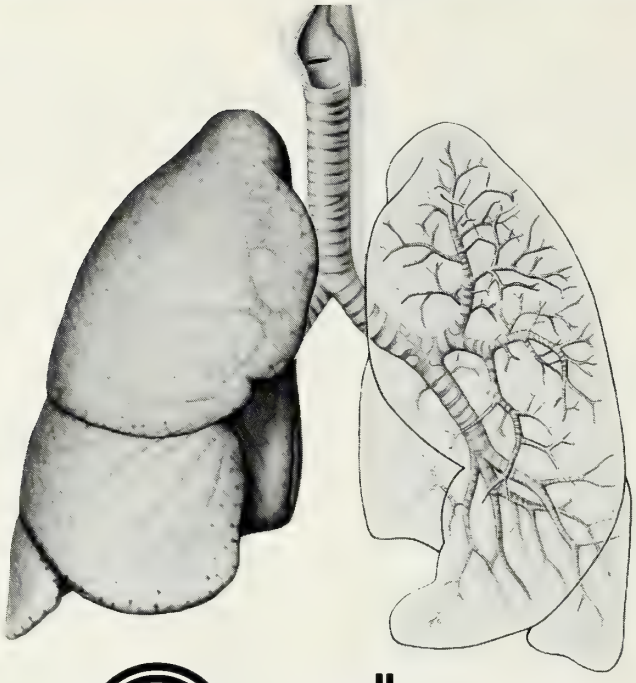
AWARDS

Officers and trustees completing terms of office were presented plaques in appreciation of their service.

Certificates of appreciation were presented to ISMS staff members Robert Burger and Jeffrey Holden for 10 years of service, and Mary Ellen Durkin, 15 years.

(Continued on page 456)

Consider the causative organisms...



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H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
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Brief Summary. Consult the package literature for prescribing information

Indications and Usage: Ceclor (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out

Precautions: *General Precautions* — If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy — *Pregnancy Category B* — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers — Small amounts of Ceclor® (cefaclor, Lilly) have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

{061782R}

Note: Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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The Long QT Syndrome

Syncope Versus Seizure

By C. Mongkolsmai, M.D./Springfield

Syncopal attacks in three children with long QT syndrome were initially diagnosed as seizures. Awareness of long QT syndrome in the differential diagnosis of seizure is emphasized. Electrocardiogram should be performed in the patients with atypical seizures to rule out the long QT syndrome. QT prolongation in some patients with this syndrome is very subtle and the diagnosis may be missed unless the QT interval is specifically measured when the ECG is performed.

Prolongation of the QT interval on the electrocardiogram represents delayed repolarization of the ventricular myocardium. Prolongation of the QT interval may be associated with serious ventricular arrhythmias, syncope and sudden death.[1-9] The hereditary prolongation of the QT interval was first described in children with congenital nerve deafness by Jervell and Lange-Nielsen.[1] A similar syndrome in the absence of deafness was described independently by Romano[2] and by Ward.[3] The inheritance of the primary long QT syndrome is usually autosomal recessive in patients with congenital nerve deafness,[7] and autosomal dominant in patients with normal hearing.[6] Sporadic examples also occur.[9] Treatment with beta-sympathetic blockers has favorably altered the prognosis of this condition.[8,9] Phenytoin, phenobarbital, the use of a pacemaker and cervicothoracic sympathetic ganglionectomy have also been used as adjunctive therapy.[9]

The purpose of this paper is to emphasize that severe ventricular arrhythmia causing syncope in patients with long QT syndrome should be included in the differential diagnosis of atypical seizure. Although considered "rare," long QT syndrome has been diagnosed in three index children residing in Southern Illinois over the past three years and long QT interval documented in several adult relatives of these children, some of whom had history of fainting or arrhythmia.

Patient 1

A 26-month-old boy was referred for evaluation of possible seizures of six months' duration. He had had two sudden, transient episodes when he could not be aroused for a few minutes after he cried at night. The third episode, at 22 months of age, had occurred at 2:00 a.m. The parents had found the child to arch his back then became unresponsive, pale, limp, diaphoretic, and apneic after he had screamed following a loud siren. Cardiopulmonary resuscitation was performed by his father. When seen in the emergency room 20 minutes later, he had a normal physical examination except for slight otitis media. He was later admitted to a local hospital where two electroencephalograms, skull radiographs, and CT scans were reportedly normal. Several electrocardiograms revealed junctional rhythm; and although all of the ECG tracings revealed long QT interval, only one was reported to have this finding (Figure 1A). His serum electrolyte, calcium and magnesium values were normal. He had two more severe episodes that required cardiopulmonary resuscitation at the age of 25 months, one of which was documented to include ventricular fibrillation and occurred while he was being monitored in the hospital (Figure 1B). He was treated with phenytoin and was referred for cardiac evaluation because of documented severe ventricular arrhythmia. There was no family history of seizure, syncope, arrhythmia, deafness or sudden death.

The cardiac examination and the rest of the physical examination of this 12.3kg boy was normal. Continuous ECG monitoring revealed persistent prolongation of the QT interval with no significant arrhythmia. He was treated with propranolol hydrochloride 10mgq 6 hrs,

and had no recurrence of syncope during the 2½ years of follow-up.

Both parents and two siblings have normal hearing, and normal QT interval on the ECG.

Patient 2

A seven-year-old girl had three episodes of sudden loss of consciousness, eyes rolling back, limpness, and pallor lasting 10 to 15 minutes, which required mouth-to-mouth resuscitation at age four years, six years and seven years. The emergency room physicians and her pediatrician suspected the diagnosis of seizures. Electroencephalograms performed after the first and second episodes were normal. All of the episodes occurred after a long period of exercise or "nervousness."

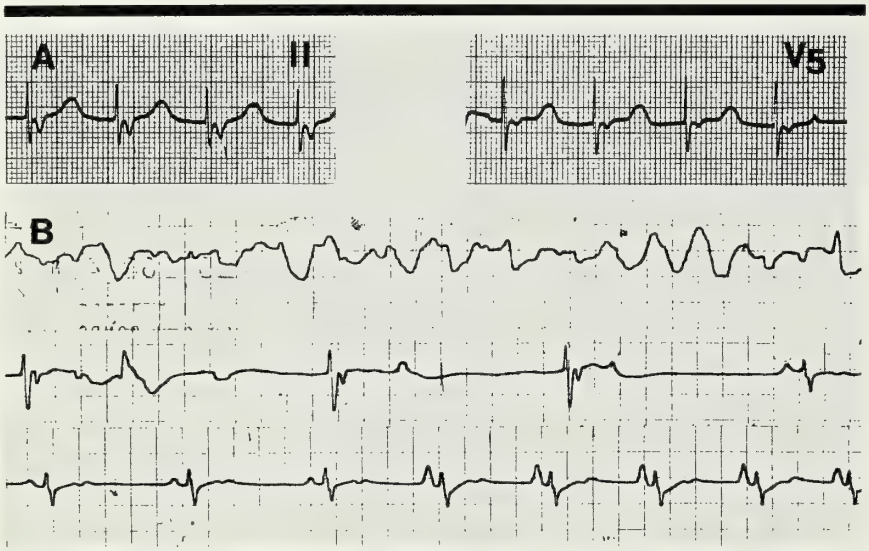


Figure 1—Patient 1.
A. Junctional rhythm and long QT interval, QT 0.48 sec, upper limit for heart rate 0.36 sec.[11]

B. Ventricular fibrillation during one of the syncopal attacks, responding to cardiopulmonary resuscitation.

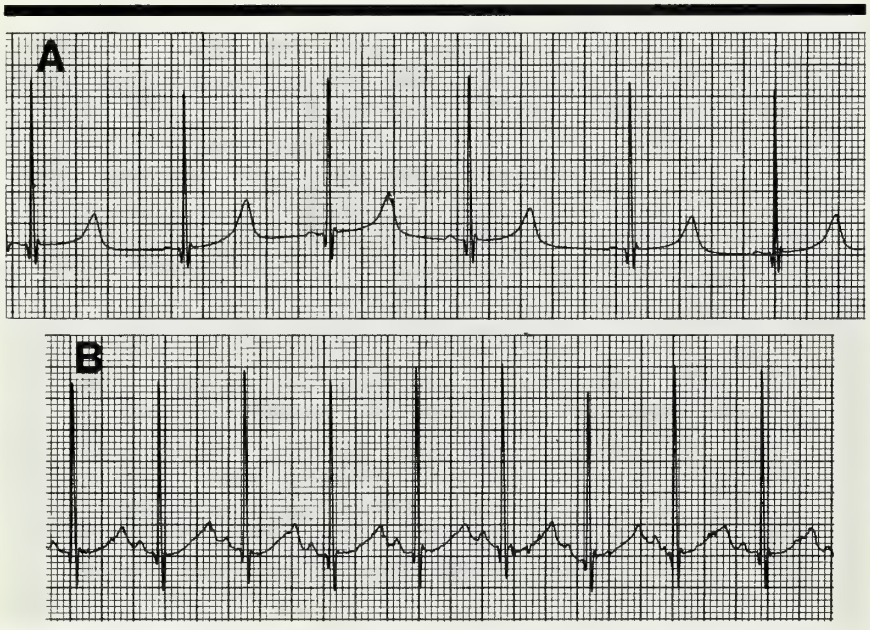


Figure 2—Patient 2.
A. Long QT interval at rest, QT 0.52 sec, upper limit for heart rate 0.40 sec.[11]

B. Persistent prolongation of the QT interval with exercise.

The cardiac examination and the rest of the physical examination of this 22.3kg child was normal. The serum potassium, calcium, and magnesium values were normal. She had no arrhythmia detected by 24 hour ECG monitoring before and after treatment with propranolol hydrochloride 60mg/day (2.7 mg/kg/day), and had no symptoms during two years of follow-up. An ergometer exercise stress test revealed long QT interval at rest which persisted during exercise (Figure 2). There were slightly blunted heart rate and blood pressure responses, secondary to propranolol administration. The work capacity was normal.[10]

The family history revealed a maternal aunt who "drowned" when she was eight years of age. She became unresponsive and could not be resuscitated after holding her breath under the water in competition with her friend. As a result of the diagnosis of long QT syndrome in our patient, the mother, maternal grandmother, and one maternal aunt were found to have long QT interval on the ECG which persisted with exercise. The father and maternal grandfather had normal ECG. One maternal great aunt had borderline prolonged QT interval. Her 13 year old daughter with congenital mild bilateral sensorineural hearing loss had borderline prolonged QT interval which became normal with exercise. No other family member has a history of syncope or seizure excepting the history of occasional "fainting" in the maternal aunt. The maternal grandmother has frequent premature atrial contractions and systemic hypertension, and is treated with propranolol.

Patient 3

This 8½-year-old boy who was initially thought to have seizure and

treated with IV diazepam was diagnosed to have long QT syndrome after he developed cardiac arrest and documentation of ventricular tachycardia and fibrillation. The detail history of this patient has been published elsewhere.[12]

Discussion

A significant number of children with long QT syndrome have been diagnosed as epileptic.[4-6] The attacks are caused, however, by ventricular tachycardia or fibrillation,[4-6] resulting in cerebral hypoperfusion and a sudden loss of consciousness. Convulsions and urinary incontinence may occur.[4-6] The attacks are usually provoked by physical or emotional stress.

All of the patients described in this paper manifested extreme pallor and apnea in addition to some seizure activity, and received a transient period of mouth-to-mouth resuscitation. The physical examination performed by the physicians minutes after the attack was normal, with no evidence of arrhythmia. That the ventricular tachycardia, flutter or fibrillation in this condition may be transient should be emphasized.[9] The resuscitative effort by the observers of patients with suspected seizures should be considered a clue against typical seizures in children and may be a clue to the diagnosis of long QT syndrome, especially when the attacks are provoked by physical or emotional stress. An ECG should be performed in such patients.

The QT interval varies with heart rate. The upper limit of normal interval for different heart rates has been established.[11] Prolongation of the QT interval may result from secondary causes. When metabolic abnormalities (*e.g.*, hypocalcemia, hypokalemia, hypomagnesemia), ingestion of drugs which can prolong the QT interval (*e.g.*, phenothiazine, imipramine and other tricyclic antidepressants, quinidine, procainamide and other antiarrhythmic agents), and other less common secondary causes of long QT interval[9] are excluded, the diagnosis of primary long QT syndrome can be made. A long QT interval was not initially reported in the ECG of two of our patients. The prolongation of the QT interval may not always be obvious, and specific attention should be paid to measure the QT interval accurately in patients suspected of having the long QT syndrome. Prolonged QT interval was reported on one ECG of the first patient, but the diagnosis of long QT syndrome was not considered by the physicians caring for the patient.

Once the diagnosis of long QT syndrome is established, screening of family members for long QT interval should be performed. The frequency and severity of the syncopal attacks vary greatly.[6,8] At least four family members of our patients were found to have long QT interval with ECG screening, and the one who "drowned" probably had the syndrome. These asymptomatic family members should be counselled to avoid sympathomimetic amines and drugs which can prolong the QT interval. They should have close cardiac monitoring during stress related to necessary medical care, such as surgery and anesthesia.

The relative infrequency of the long QT syndrome may have resulted in a lack of emphasis of this condition during pediatric training. However, this condition is not rare and may be frequently unrecognized.[8,9]

Addendum

An 18-year-old previously asymptomatic sister of patient three with long QT intervals has since developed three episodes of "seizure-like" activity and ventricular tachycardia and fibrillation. This adds another documented patient with long QT syndrome in southern Illinois.

Acknowledgement

Dr. Joseph M. Garfunkel's advice and thoughtful review of the manuscript is greatly appreciated. ◀

Chalermlarp Mongkolsmai, M.D., is a board certified pediatrician with subspecialty certification in pediatric cardiology affiliated with St. John's Hospital and Memorial Medical Center in Springfield. An assistant professor of pediatrics at the SIU School of Medicine, Dr. Mongkolsmai is a fellow of the American Academy of Pediatrics and the American College of Cardiology.

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A Response to the Malpractice Crisis

Physician Support Group Formed

By Sara C. Charles, M.D./Chicago

The ISMS Ad Hoc Committee on Loss Prevention Education seeks to help physicians identify medical practice settings and procedures related to professional liability issues. Educational programs seek to enhance quality of medical care and understanding of the medical/legal environment. As an extension of that work, the Committee has appointed a Subcommittee on Physician Support Groups, chaired by the author. Further information may be obtained by contacting the Illinois State Medical Society, Division of Medical Education, Twenty North Michigan Avenue, Chicago IL 60602.

ISMS has added a new facet to its overall initiative to combat the many negative aspects of the current malpractice crisis. A new Physician Support Group has been formed through the Committee on Loss Prevention Education to help physicians deal with the very real psychological pressures that a malpractice claim can bring about.

Although many persons outside the medical profession suggest that litigation is only part of the "cost of doing business" in today's world, the repercussions of a legal assault for the individual physician are far from inconsequential. The personal and professional life of the physician may be profoundly affected.

Legal action is generally perceived as a major life stress. It may be even more stressful for a physician because it challenges the very core of professional integrity. This, in turn, affects not only the doctor-patient relationship but also the freedom to make clinical judgments.

A physician may react to the stress of litigation in a multiplicity of ways. Severe anger, headache, or a depressed mood are common reactions to lawsuits. These responses do not indicate ineffectiveness in coping with the assault. Nor do they suggest fundamental impairment. These responses simply indicate the physician is human, like any other person, and is dealing with an enormously stressful event in life.

The very nature of a physician's work demands that feelings and reactions be held in check, in order to carry out the expected responsibilities to patients and colleagues. When confronted with a lawsuit, personal reactions may become so overwhelming that conflict and tension arise between the needs of the individual physician and the needs of his or her patients.

Response to the Problem

One effective means to cope with such tensions is to share reactions with others who have had similar experiences. The Committee on Loss Prevention Education has established a referral panel of physicians who are available to talk with doctors who are currently involved in litigation. Any Illinois physician who feels the need for such support can be put in touch with a member of the panel. All referrals are made in strict confidence.

Philosophy of the Program

- Physicians who react to the stress of malpractice litigation are not impaired physicians. Rather they are generally highly trained and well functioning physicians who are confronted with a major life stress.
- The guidelines of the program are designed to maintain the utmost confidentiality and pro-

tection for the physician.

- Initially, this program will respond only to the physician. Communication with the Auxiliary has been established. Their plans in response to the effects on the spouse and family are currently a separate endeavor.
- Communication between the physician and panel member will be held confidential. There will be no written record of the meeting.
- The intention of the program is *not* to provide therapy but rather to provide an informal and sympathetic listener for the stressed physician.
- If, in the opinion of the referral panel member, the physician who makes contact is clearly in need of either medical or psychiatric intervention, the panel member should—as would any associate—recommend that the physician seek proper evaluation.
- The tenor of the program is the desire of colleagues to lend support during a critical period in one's life. Legal and insurance advice is left to those respective experts.

The Physician Support Group Panel

- The referral panel consists of volunteer physicians of various specialties who have themselves had litigation experience.
- Interaction between the requesting physician and the member of the panel should be tailored to the needs of the situation. This means that the time, place, and subject matter discussed are determined by the participants.
- Members of the panel should keep a coded record of contact with the physician for statistical purposes.

Procedure to Contact the Panel

- The list of referral panel members (including their specialty and primary hospital affiliation) will be kept on file with the medical society contact person. A doctor may request a known member of the panel; otherwise the phone number of a panel member will be given on a rotating basis. If contact cannot be made, another name and number will be given.
- A coded card will be completed by the referral panel member and by the medical society contact person for statistical purposes.
- To contact a member of the panel, please call (312) 782-1654, extensions 1145 or 1147.

Conclusion

The problem of medical malpractice is an insidious one. It affects physicians not only professionally and economically, but also psychologically. The Illinois State Medical Society is seeking to combat the far reaching effects of the malpractice crisis. Efforts include legislative and educational programs for the profession and the public about the malpractice problem. Individualized collegial concern for those doctors who are experiencing the assault of a malpractice lawsuit is a core aspect. It is hoped that the Physician Support Group will be an effective intervention to one of the most serious effects of the problem of medical malpractice. ◀

Sara C. Charles, M.D., is a board certified psychiatrist and associate professor of clinical psychiatry affiliated with the University of Illinois College of Medicine, Chicago. An examiner in psychiatry for the American Board of Psychiatry and Neurology, Dr. Charles is an alternate delegate from the American Psychiatric Association to the Council of Medical Specialty Societies. Dr. Charles and her husband, Eugene Kennedy, have co-authored a book, "Defendant: A Psychiatrist on Trial for Medical Malpractice," to be published this month by The Free Press of MacMillan, New York.

Obituaries

****Baumann, Charles H.,** Belleville, died March 4, 1985 at the age of 84. Dr. Baumann was a 1925 graduate of the St. Louis University School of Medicine.

****Beilin, David S.,** Pebble Beach, California (formerly of Chicago), died March 18, 1985 at the age of 91. Dr. Beilin was a 1919 graduate of the University of Illinois College of Medicine, Chicago.

***Berfield, Charles M.,** Princeton, died March 19, 1985 at the age of 60. Dr. Berfield was a 1951 graduate of the University of Illinois College of Medicine, Chicago.

***Buchsbaum, Zygmunt,** Chicago, died April 7, 1985 at the age of 72. Dr. Buchsbaum was a 1950 graduate of Medizinische Fakultat der Ludwig Maximiliams-Universitat, Munchen, Bayern, Germany.

***Carr, Bradley W.,** Glenview, died April 1, 1985 at the age of 66. Dr. Carr was a 1943 graduate of Northwestern University Medical School, Chicago.

****Holten, Edmund H.,** Belleville, died February 21, 1985 at the age of 85. Dr. Holten was a 1929 graduate of the University of Illinois College of Medicine, Chicago.

****Jones, Robert M.,** Winnetka, died April 5, 1985 at the age of 83. Dr. Jones was a 1929 graduate of Rush Medical College, Chicago.

***Margolis, David J.,** Portland, Oregon (formerly of Chicago), died April 7, 1985 at the age of 93. Dr. Margolis was a 1917 graduate of Rush Medical College, Chicago.

***Nicolas, Aristhomene,** Chicago, died April 18, 1985 at the age of 63. Dr. Nicolas was a 1947 graduate of Faculte de Medecine et de Pharmacie de l'Universite d'Haiti, Port-Au-Prince, Haiti.

****Norris, Reginald M.,** Jacksonville, died April 5, 1985 at the age of 86. Dr. Norris was a 1926 graduate of Northwestern University Medical School, Chicago.

***Palumbo, Joseph L.,** Rochelle, died April 1, 1985 at the age of 67. Dr. Palumbo was a 1943 graduate of the University of Health Sciences/Chicago Medical School.

****Perkins, William C.,** West Chicago, died April 7, 1985 at the age of 75. Dr. Perkins was a 1934 graduate of Northwestern University Medical School, Chicago.

****Portes, Caesar,** Chicago, died April 12, 1985 at the age of 87. Dr. Portes was a 1929 graduate of the University of Health Sciences/Chicago Medical School.

****Stoops, Richard B.,** Boca Raton, Florida, died March 16, 1985 at the age of 87. Dr. Stoops was a 1924 graduate of the University of Illinois College of Medicine, Chicago.

***Whitsell, David C.,** Hinsdale, died April 4, 1985 at the age of 54. Dr. Whitsell was a 1956 graduate of Jefferson Medical College, Thomas Jefferson University, Philadelphia, Pennsylvania.

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*

Abstracts of Board Actions

(Continued from page 445)

PROGRAMS

The Board approved the development of:

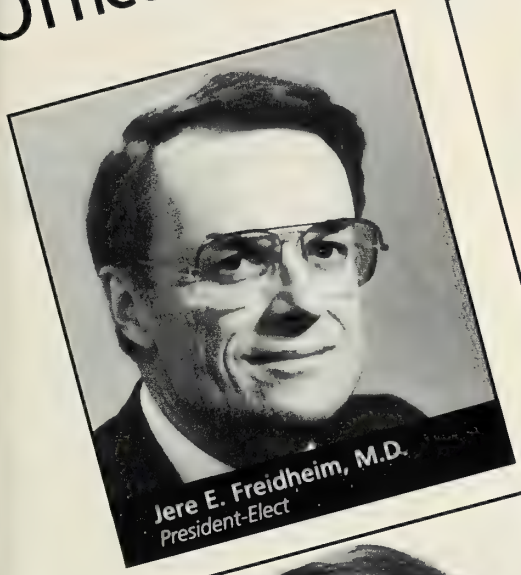
- The first Midwest Conference on the Impaired Physician.
- Two intervention training programs for physicians serving as Intervenors/Monitors who would assist the Committee in identifying, confronting and assisting impaired physicians.
- A communication course for doctors who do not have English as a first language.
- Directed that the Task Force on Sponsored Insurance Programs conduct a telephone survey with CMP Financial Services. This would sample a segment of physicians in Illinois to determine their interest in membership insurance programs. The cost of the survey would be limited to the cost of the long distance calls.

NEXT MEETING

The Board set the next Board of Trustees meeting for June 8-9, 1985, at ISMS Headquarters.

ISMS Annual Meeting Summary

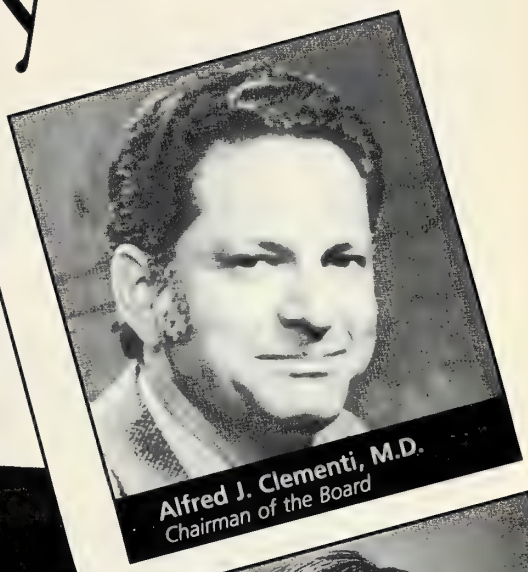
1985-1986 Officers



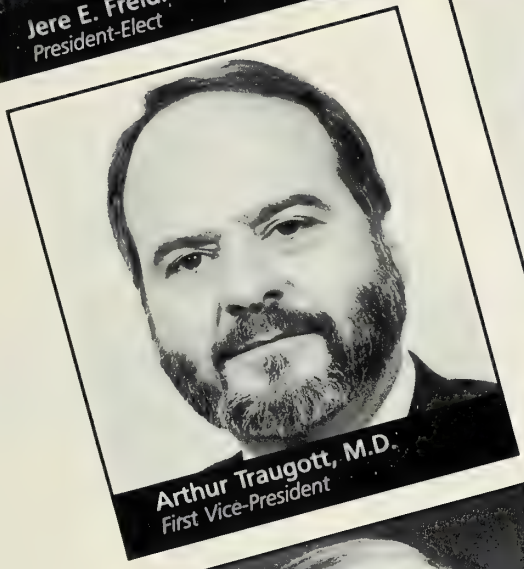
Jere E. Freidheim, M.D.
President-Elect



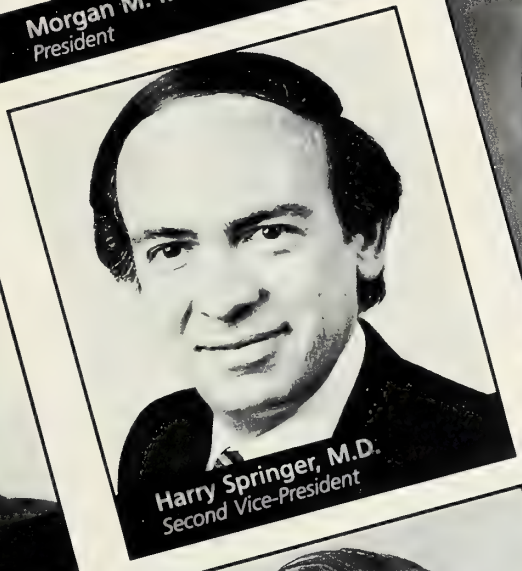
Morgan M. Meyer, M.D.
President



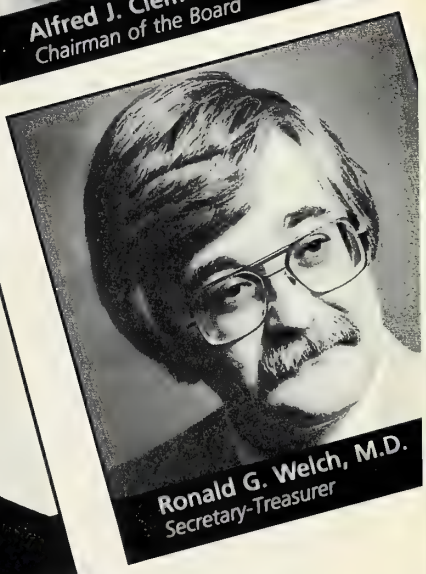
Alfred J. Clementi, M.D.
Chairman of the Board



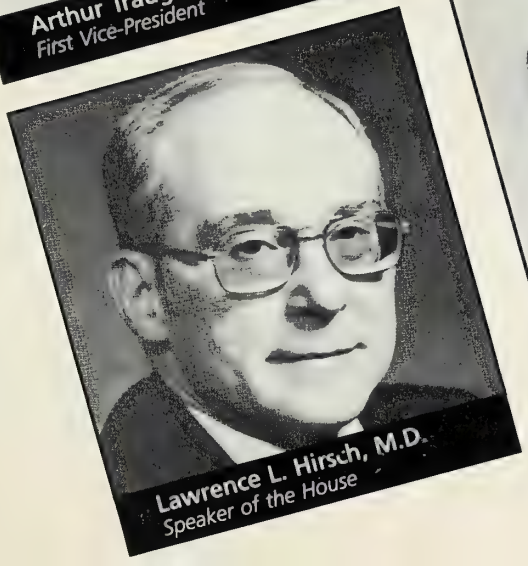
Arthur Traugott, M.D.
First Vice-President



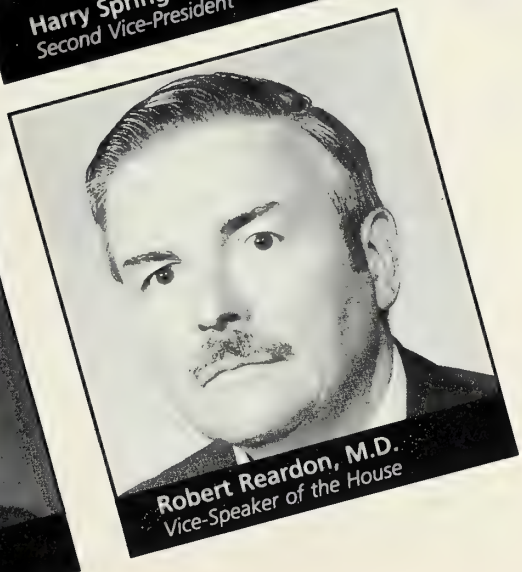
Harry Springer, M.D.
Second Vice-President



Ronald G. Welch, M.D.
Secretary-Treasurer



Lawrence L. Hirsch, M.D.
Speaker of the House



Robert Reardon, M.D.
Vice-Speaker of the House

1985 ANNUAL MEETING HOUSE OF DELEGATES

The ISMS House of Delegates met at the Chicago Marriott O'Hare in Chicago, April 26-28, 1985, and took the following actions. The official minutes of the House are on file at the headquarters office of the Illinois State Medical Society.

UNFINISHED BUSINESS

Substitute 1 (A-84) Adopted
(BOT Report B)—Eligibility for Retired Member Status
Introduced by Raymond E. Hoffmann, M.D., for the Winnebago County Medical Society

Substitute 17 (A-84) Adopted in Lieu of 17 & 18 (A-84)
Reduced Dues and Waived Dues
Introduced by Raymond A. Dieter, Jr., M.D., for the DuPage County Medical Society

Directed that Chapter I of the ISMS Bylaws be amended to read as follows:

CHAPTER I. MEMBERSHIP
Section 1. Members.
C. Retired Members. . . . Retired status is not available to physicians who assume compensated positions in the health care field after retiring from medical practice.

CHAPTER II. DUES AND ASSESSMENTS
Section 2. Reduction and Remission of Dues.
. . . The Board of Trustees may authorize remission of dues of any member based upon annual review and recommendation of his component society, for good reason. In such cases . . .

Substitute 20 (A-84) Adopted
(BOT Report C)—Insanity As A Defense
Introduced by Alfred J. Clementi, M.D., for the Board of Trustees

Directed that: (1) ISMS support the concept that a person may be found innocent of a crime by reason of having severe mental illness or retardation; (2) For a person to use insanity as a defense the severity of the person's mental condition should be shown to exhibit an inability to know the nature of his conduct at the time of the offense, and that he was unaware that the act was wrong and personally or socially destructive to himself or someone else; (3) Testimony by medical experts on the nature of a person's mental condition should be limited to the diagnosis, mental state and motivation of an individual and not on whether the person is "sane" as determined by legal standards; and (4) A person found innocent by reason of insanity should be provided treatment and ongoing supervision to ensure the public is protected, and when psychiatric treatment can no longer help an individual, who is still considered dangerous, that person should be transferred to a nonmedical facility for further supervision.

24 (A-84) Not Adopted
(BOT Report D)—Patient Communication
Introduced by Harry A. Springer, M.D., Chairman, Cook County Delegation

Defeated this resolution, which called upon ISMS to adopt the following policy statement: The Illinois State Medical Society believes that any decision that could affect the medical care of a patient should be reported to the patient or his/her legal representative by the person, persons, or organization making the decision.

REFERENCE COMMITTEE ON CONSTITUTION & BYLAWS

2 (A-85) Adopted
Policy Statement on "Blood Availability"
Introduced by Alfred J. Clementi, M.D., for the Board of Trustees

Amended the ISMS Policy Manual Statement on "Blood Availability" as follows:

BLOOD AVAILABILITY
Since the use of a replacement or penalty fee has been eliminated in this state, ISMS encourages component societies to promote

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the public's full acceptance of the concept of truly altruistic blood donation and community responsibility.

The Illinois State Medical Society and its component societies should strongly encourage hospitals and any other facilities to affiliate with a regional blood center in their areas.

The Illinois State Medical Society and its component societies should assist appropriate organizations in establishing a regionally coordinated blood banking system throughout the state and areas contiguous to the state.

3 (A-85) Adopted
ISMS Policy Statement on "Reconstructive Surgery"
Introduced by Alfred J. Clementi, M.D. for the Board of Trustees

Amended the ISMS Policy Manual Statement on "Reconstructive Surgery" as follows:

RECONSTRUCTIVE SURGERY

Reconstructive surgery is surgery which is intended to correct deformities caused by disease or accident.

5 (A-85) Adopted
ISMS Policy Statement on "Advertising"
Introduced by Alfred J. Clementi, M.D. for the Board of Trustees

Directed that the ISMS policy statement on "Advertising" be deleted and that the state law on physician advertising be included in all future *Illinois Medical Journal* reference issues, with amendments to the law included for the information of all ISMS members.

6 (A-85) Adopted
County Societies
Introduced by Alfred J. Clementi, M.D. for the Board of Trustees

Amended Bylaws as follows:

CHAPTER X. COUNTY SOCIETIES

Section 9. The Secretary of each component society shall forward a list of current officers, delegates and alternate delegates to the secretary of this society no later than 90 days prior to the Annual Meeting.

18 (A-85) Not Adopted
Terms of Office of Delegates to the AMA
Introduced by Paul M. Norris, M.D. for the Peoria Medical Society

Defeated this resolution which called upon ISMS to limit the number of consecutive terms that may be served by a delegate to the AMA.

19 (A-85) Not Adopted
Geographic Location of ISMS Meetings
Introduced by James R. DeBord, M.D. for the Peoria Medical Society.

Defeated this resolution which called upon ISMS to amend Chapter IV, Sections 4 and 6 to state that the location of the Annual, Interim and Special Meetings of the House of Delegates be located within the state of Illinois.

39 (A-85) Adopted
Amendment to Chapter IV, Sections 1 and 3, and Deletion of Chapter IX, Section 5, of the ISMS Bylaws
Introduced by Alfred J. Clementi, M.D. for the Board of Trustees

Directed that: (1) Chapter IX ("Committees"), Section 5 (H. "Committee on Hospital Medical Staffs") be deleted from the ISMS Bylaws; and (2) Chapter IV, Sections 1 and 3 be amended as follows:

CHAPTER IV. HOUSE OF DELEGATES

Section 1. Composition. The voting membership of the House of Delegates shall consist of 1) delegates elected by component societies, 2) the President, 3) the President-Elect, 4) the Vice President, 5) the Secretary-Treasurer, 6) the Speaker and Vice Speaker, 7) Trustees, 8) one delegate elected by the Resident Physician's Section, 9) one delegate elected by the Medical Student Section and 10) one delegate elected by the Hospital Medical Staff Section.

Section 3. Affiliate Group Delegates. There shall be a Resident Physician Section and a Medical Student Section, which shall be open, respectively, to all in-training and medical student members of ISMS. There shall also be a Hospital Medical Staff Section, which shall be comprised of ISMS members elected to represent individual hospital medical staffs. The business of each organization shall be conducted by a governing council in accordance with bylaws approved by the ISMS House of Delegates. The governing council of each organization shall include one delegate with vote in the ISMS House of Delegates and one alternate delegate; and . . .

(3) The Constitution and Bylaws of the ISMS Hospital Medical Staff Section, be adopted.

REFERENCE COMMITTEE A

9 (A-85) Adopted As Amended
Membership Dues Stabilization
Introduced by Harlan Failor, M.D., Lewis Trupin, M.D. and Robert Welke, M.D. for the Champaign County Medical Society

Directed that the Society: (1) Reflect on the delicate balance of dues and memberships: (2) Maintain dues reasonableness within the context of budgetary reviews and long-range planning, thus preserving medicine's strength by member involvement and participation; and (3) Introduce a similar resolution to the 1985 Annual Meeting of the AMA House of Delegates.

12 (A-85) Not Adopted
Legal Defense Insurance
Introduced by Edward K. DuVivier, M.D. for the Madison County Medical Society

Defeated this resolution which called upon ISMS to recommend that ISMIE develop a legal defense insurance separate from professional liability insurance. Thus, ISMS members could carry a legal defense protection policy to reimburse legal defense costs and professional liability

insurance to protect against professional liability awards.

13 (A-85) Not Adopted
Attorneys
Introduced by Edward K. DuVivier, M.D. for the Madison County Medical Society

Defeated this resolution which called upon ISMS to encourage the component county medical societies to keep a roster of attorneys for information to their members with a current tabulation of their legal activities.

16 (A-85) Not Adopted
Malpractice Reform by Constitutional Amendment
Introduced by Lorris M. Bowers, M.D. for the Peoria Medical Society

Defeated this resolution which called upon ISMS to formulate malpractice reform via a petition drive to put a constitutional amendment on the November, 1986 ballot, and for the BOT to report back to the HOD in this regard at the 1985 Interim Meeting or earlier if feasible.

17 (A-85) Substitute Adopted
AMA Membership
Introduced by Lorris M. Bowers, M.D. for the Peoria Medical Society

Directed that the ISMS Delegation to the AMA request the AMA to seek additional incentives to encourage unified membership.

21 (A-85) Referred to Board for Study
D & O Insurance
Introduced by Theodore M. Kanellakes, M.D. for the Will-Grundy County Medical Society

Referred to the Board of Trustees for study a proposal that the county medical societies be provided the opportunity of securing Directors and Officers Insurance by means of a rider attached to the Illinois State Medical Society's existing policy.

32 (A-85) Adopted
Duties of the ISMS Board of Trustees' Executive Committee in Regard to the Illinois Council on Continuing Medical Education
Introduced by Alfred J. Clementi, M.D. for the Board of Trustees

Directed that the Society's Executive Committee: (1) Is authorized and directed to act, in their role as corporate members of ICCME, to fulfill the adopted purposes of ICCME; (2) Exercise this House's prerogatives regarding ICCME between meetings of this House; and (3) Report its activites as corporate members of ICCME to each annual meeting of this House.

REFERENCE COMMITTEE B

1 (A-85) Substitute Adopted
Usual, Customary or Reasonable Reimbursement
Introduced by Alfred J. Clementi, M.D. for the Board of Trustees

Directed that the: (1) Current policy statement on "Usual and Customary or Reasonable Reimbursement" be deleted; and (2) ISMS Policy Manual Statement on "Reimbursement, Physician" be amended to read as follows:

REIMBURSEMENT, PHYSICIAN
It is desirable to afford maximum flexibility and latitude in creating an economic environment acceptable to the individual physician's right to choose which method of economic reimbursement for care that best suits the needs of that physician and his/her patients. Where appropriate, ISMS supports the right of physicians to seek payment from patients for the difference between the physician's charges and the amount of payment an insurance carrier pays. To the extent practicable, ISMS should strive to assist physicians in understanding alternative reimbursement systems, including but not limited to Usual and Customary or Reasonable (UCR).

7 (A-85) Referred to Board for Study
Capitated Health System Insolvency Insurance
Introduced by Jere E. Freidheim, M.D., Chairman, Cook County Delegation

Referred to the Board of Trustees for study a proposal that ISMS seek the passage of legislation that would require all capitated health systems to purchase patient protection insolvency insurance that would assure continuity of care for the remainder of the capitated contract period.

8 (A-85) Not Adopted
Malpractice Premiums
Introduced by Samuel J. Schimel, M.D.

Defeated this resolution which called upon the Society to enter into negotiations on behalf of all Illinois physicians with all insurance carriers selling malpractice insurance in the State of Illinois to freeze the malpractice premiums for two years.

10 (A-85) Adopted as Amended
PPO Terminology
Introduced by William P. Gibbons, M.D. for the DuPage County Medical Society

Directed that the Society: (1) Use the term "contract physician provider" in lieu of "preferred provider" and the term "contract provider organization" in lieu of "preferred provider organization" in all internal and external communication and when discussing such providers and organizations; (2) Introduce a similar resolution at the next meeting of the House of Delegates of the American Medical Association; and (3) Implement this policy as feasible in the next seven months.

22 (A-85) Adopted as Amended
Federal Policy Favoring HMO's
Jere E. Freidheim, M.D., Chairman, Cook County Delegation

Directed that the Society introduce a resolution into the House of Delegates of the American Medical Association, directing that legislation be drafted and supported amending the current

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federal policy so that in addition to offering an HMO, employers must also make the traditional fee-for service option available to employees if a health care benefit is provided.

25 (A-85) Referred to Board for Study
Nursing Home Residents
Introduced by Kishore J. Thampy, M.D.

Referred to the Board of Trustees for study a proposal that ISMS: (1) Introduce legislation in the state General Assembly enabling the expenditure of state funds to subsidize the federal program; and (2) Delegates to the AMA introduce a similar resolution in the AMA House of Delegates to authorize additional federal payments to nursing home residents.

31 (A-85) Referred to Board for Study
Medicare and Its Effect on Resident Programs
Introduced by Charles Cattano, M.D., for the ISMS Resident Physicians Section

Referred to the Board of Trustees a proposal that ISMS study the effect of Medicare changes on: (1) The number and quality of resident training programs in Illinois; (2) The number of Illinois residents; (3) The types of specialty and sub-specialty programs; (4) The closing of hospitals and teaching hospital programs; (5) The expenditures on graduate medical education; (6) Resident salary; and (7) Other health professional training programs.

38 (A-85) Adopted as Amended
Medicare Review Process
Introduced by Forrest H. Riordan, III, M.D. for the Winnebago County Medical Society

Directed that the Society encourage the Medicare Part B carrier for Illinois to: (1) Make available on request its criteria for determining medical necessity; (2) Establish a review process that will take no longer than four weeks; and (3) Have open communication with physicians regarding grievances.

REFERENCE COMMITTEE C

14 (A-85) Substitute Adopted as Amended
Medical Staff Privileges
Garth D. Smith, M.D. for the DuPage County Medical Society

Directed that the Society adopt the position that a physician's hospital privileges should be based essentially on clinical competency and quality of care.

15 (A-85) Adopted as Amended
Free-Standing Ambulatory Care Clinical Laboratories
Introduced by Erlo Roth, M.D. for the DuPage County Medical Society

Directed that the Society oppose any attempts to change the Illinois Clinical Laboratory Act by exempting commercial laboratories or freestanding laboratories and clinics operated by hospitals from meeting the standards of this Act.

20 (A-85) Adopted as Amended
The Roles of a Medical Staff and Governing Board in Credentialling
Introduced by Donal D. O.'Sullivan, M.D.

Directed that the Society recognize it is the right and duty of a: (1) Medical staff organization to evaluate the credentials of all applicants for medical staff privileges, according to objective, predetermined criteria of acceptability; and (2) Hospital governing body to grant privileges to those applicants found acceptable and desirable as members of the medical staff.

23 (A-85) Substitute Adopted
Discrimination Against Physicians
Introduced by Kishore J. Thampy, M.D.

Directed that the Society: (1) Take the position that the quality of medical training is an appropriate concern in the recruiting and credentialling of physicians, however, it is inappropriate to discriminate against any physician because of national origin or country of schooling; and (2) Introduce a similar resolution to the next meeting of the AMA House of Delegates.

27 (A-85) Substitute Adopted
Impaired Physician Activities
Introduced by Charles Cattano, M.D. for the Resident Physicians Section

Called upon the Society and its individual members to recognize the importance and need to promote, support and participate in state, local and hospital activities to prevent, recognize and overcome impairment among medical students, residents and practicing physicians.

33 (A-85) Substitute Adopted
Hospital Clinical Training Program
Introduced by Alfred J. Clementi, M.D. for the Board of Trustees

Directed that the Society support the introduction of legislation that would provide that only medical students attending medical schools approved by the Illinois Department of Registration and Education be permitted clinical clerkships in licensed Illinois hospitals.

REFERENCE COMMITTEE D

4 (A-85) Adopted as Amended
ISMS Policy Statement on "Smoking"
Introduced by Alfred J. Clementi, M.D. for the Board of Trustees

SMOKING

The Illinois State Medical Society, as a matter of policy, publicly adopts a vigorous stand against cigarette smoking because it is a major health hazard. The Society will work with other agencies inside and outside medicine to eliminate this contributable cause of death, disability and rising health care cost. ISMS will support appropriate legislative initiatives to communicate the

risks of tobacco to all, particularly young people.

ISMS is opposed to the sale of tobacco and tobacco products in hospitals and encourages medical staff action to make hospitals tobacco-smoke free, except for certain areas designated for smoking. It supports the prohibition of smoking in public places, except for certain areas designated for smoking.

Physicians should refrain from smoking during professional patient visits. Exemplary abstinence during social contacts by physicians and their employees with the public in general is highly desirable. Literature and signs concerning the health hazards of smoking should be displayed in medical offices and other public places over which health care professionals have control.

11 (A-85) Substitute Adopted as Amended
Inappropriate Use of Procedures to Improve Athletic Performance
Introduced by Raymond A. Dieter, M.D. for the DuPage County Medical Society

Directed that the Society oppose the use of such items as, but not limited to, hormones, drugs and blood transfusions solely to improve athletic performance.

24 (A-85) Referred to Board for Study
Psychiatric Care in State Hospitals
Introduced by Kishore J. Thampy, M.D.

Referred to the Board of Trustees for study a proposal that ISMS urge the Department of Mental Health to recruit more psychiatrists, and to require that patients admitted to a State hospital be evaluated and treated by a psychiatrist on a regular basis.

28 (A-85) Not Adopted
Non-smoking Areas in Restaurants
Introduced by Erlo Roth, M.D.

Defeated this resolution which called upon the Society to support legislation mandating that all restaurants in the State of Illinois set aside areas for smokers.

29 (A-85) Referred to Board for Study
Specified Frequency of Physician Visits to Nursing Home Patients
Introduced by Robert M. Reardon, M.D. for the McLean County Medical Society

Referred to the Board of Trustees for study a proposal that ISMS instruct the AMA Delegation to actively seek the elimination of the regulation in the Federal Register, Volume 45, No. 136, July 14, 1980, Section 438.21, limiting physician services in the interest of cost containment.

30 (A-85) Adopted
New IRS Ruling on Automobiles
Introduced by Edwin S. Sinaiko, M.D.

Directed that the: (1) Illinois Delegation to AMA introduce a resolution in the AMA House of Delegates calling upon the AMA to present the facts of a physician's practice to the IRS; (2) AMA request that the IRS reconsider the new automobile ruling by exempting physicians because of their unique business needs; and (3) Illinois Delegation to AMA report on this matter at the next meeting of the ISMS House of Delegates.

34 (A-85) Adopted
Driving Under the Influence of Alcohol
Introduced by Alfred J. Clementi, M.D. for the Board of Trustees

Directed that the Society: (1) Support the efforts of the Illinois DUI Task Force to address the DUI problem through legislation, administration and public education; (2) Review legislation attempting to alleviate concerns relating to DUI; and (3) Recommend action as appropriate following the analysis of the aforementioned legislation.

MEMORIAL RESOLUTIONS

The House also adopted memorial resolutions in memory of Drs. Stanley Budrys, Mathew Kobak, Caesar Portes, Louis Tarsinos, Jasper Williams and Warren Young, and expressed its profound loss and condolences to their families.

26 (A-85) Not Received
ISMS Settlement on Wilk's Case
Introduced by Chester C. Danehower, M.D. for the Peoria Medical Society

ELECT OFFICERS, TRUSTEES, AMA DELEGATES

Dr. Morgan M. Meyer, Lombard, was installed as ISMS president, succeeding *Dr. Robert C. Hamilton,* Chicago.

Election of Officers

At the concluding session of the House, 1985-86 officers were elected unanimously. They are: Drs. *Jere E. Freidheim,* Chicago, president-elect; *Arthur R. Traugott,* Urbana, first vice-president; *Harry A. Springer,* Evanston, second vice-president; *Ronald G. Welch,* Belleville, secretary-treasurer; *Lawrence L. Hirsch,* Northbrook, speaker of the House and *Robert M. Reardon,* Bloomington, vice speaker of the House.

Election of Trustees

Elected trustees were: Drs. *Ulrich F. Danckers* and *William J. Marshall, Jr.,* Third District; *Lorris M. Bowers,* Fourth District; *Robert P. Johnson,* Fifth District; *Alfred J. Kiessel,* Seventh District; and *Eugene P. Johnson,* Eighth District.

Judicial Panel

Dr. Robert H. Lund, Rockford, was elected to serve a five year term on the ISMS Judicial Panel.

Illinois AMA Delegates

The House of Delegates elected AMA delegates and alternates to serve January 1, 1986 through December 31, 1987. Elected delegates were Drs. *Alfred J. Clementi, Jere E. Freidheim, Robert C. Hamilton, Harold L. Jensen, Robert P. Johnson,*

Morgan M. Meyer, Harry A. Springer, and Arthur R. Traugott. Elected alternate delegates were Drs. *Randall T. Bellows, Albino T. Bismonte, Ulrich F. Danckers, Earl E. Fredrick, Jr., A. Beaumont Johnson, Carlos B. Lara, Joseph H. Skom, Warren D. Tuttle,* and *Ronald G. Welch.*

Additional Delegate & Alternate

The House of Delegates elected *Dr. Pedro A. Poma,* Melrose Park, as the 18th delegate to take office immediately and serve until December 31, 1986 and *Dr. Allan L. Goslin,* Streator, as the 19th delegate to take office immediately and serve until December 31, 1985. *Dr. Manuel O. Guerrero,* Rock Island, was elected as the 18th alternate delegate to take office immediately and serve until December 31, 1986 and *Ms. Nancy Zamora* as the 19th alternate delegate to take office immediately and serve until December 31, 1985.

1986 Dues

The secretary-treasurer announced that the per capita dues for 1986 were set at $253.

Illinois State Medical Society 1985-1986 Board of Trustees

President		Morgan M. Meyer, M.D., 573 S. Lombard, Lombard 60148
President-Elect		Jere E. Freidheim, M.D., Mercy Hospital and Medical Center, Stevenson at King Dr., Chicago 60616
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2nd Vice-President		Harry Springer, M.D., 800 Austin St., Suite 610, Evanston 60202
Secretary-Treasurer		Ronald Welch, M.D., 333 S. Illinois, Suite B, Belleville 62220
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Vice-Speaker		Robert Reardon, M.D., 1008 N. Main St., Bloomington 61701
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1st Dist.	1987	David B. Littman, M.D., 1034 Old Elm Road, Highland Park 60035
2nd Dist.	1986	Allan L. Goslin, M.D., Route 4, Streator 61364
3rd Dist.	1986	James H. Andersen, M.D., 141 Breakenridge Farm, Oak Brook 60521
	1987	Alfred J. Clementi, M.D., 675 W. Central Rd., Arlington Hgts. 60005
	1986	Audley F. Connor, Jr., M.D., Jackson Park Hospital, 7531 S. Stony Island Ave., Chicago 60649
	1987	Joan E. Cummings, M.D., Hines VA Hospital, P.O. Box 1063, Hines 60141
	1988	Ulrich F. Danckers, M.D., 1040 Monroe Ave., River Forest 60305
	1986	Harold L. Jensen, M.D., 3235 Vollmer Rd., Flossmoor, 60422
	1988	William J. Marshall, M.D., 2601 Lincoln Hwy., Olympia Fields 60461
	1987	Arthur R. Peterson, M.D., 2740 W. Foster, Chicago 60625
	1986	Pedro A. Poma, M.D., 1200 Superior, Suite 402, Melrose Park 60160
	1987	Cyril C. Wiggishoff, M.D., 2800 N. Sheridan Rd., Suite 602, Chicago 60657
4th Dist.	1988	Lorris Bowers, M.D., 214 NE Glen Oak, Suite 600, Peoria 61603
5th Dist.	1988	Robert P. Johnson, M.D., 3000 Bennington Ave., Springfield 62704
6th Dist.	1987	George T. Wilkins, M.D., #1 Glen Ed Prof. Park, Edwardsville 62025
7th Dist.	1988	Alfred J. Kiessel, M.D., 1 Powers Lane Pl., Decatur 62522
8th Dist.	1988	Eugene P. Johnson, M.D., 521 E. Main, Casey 62420
9th Dist.	1987	Warren D. Tuttle, M.D., 203 N. Vine, Harrisburg 62946
10th Dist.	1987	Thomas P. Meirink, M.D., 8601 W. Main St., Belleville 62223
11th Dist.	1986	Raymond A. Dieter, Jr., M.D., 22 W. Stanton Rd., Glen Ellyn 60137
12th Dist.	1986	Raymond E. Hoffmann, M.D., 1030 Highview Ave., Rockford 61107
Trustee-At-Large	1986	Robert C. Hamilton, M.D., 711 W. North Ave, Chicago 60610
AMA Delegation Chairman *(Ex-Officio)*		Morgan M. Meyer, M.D., 573 S. Lombard, Lombard 60148
ISMIE Board of Governors Chairman *(Ex-Officio)*		Fred Z. White, M.D., P.O. Box 279, 525 Sweetbriar, Chillicothe 61523

Annual Meeting Highlights

The 1985 annual meeting focused on health care issues as identified in the Summary of Actions. These highlights are brief synopses of selected presentations.

Public Affairs Breakfast

Congressman John Porter (R), who represents the tenth congressional district in the U.S. House of Representatives, addressed the ISMS Public Affairs Breakfast on Saturday morning. Congressman Porter, a member of the House Committee on Appropriations and three-term veteran of the Illinois House of Representatives, identified the federal deficit as a primary issue before Congress. Acknowledging that physicians had already been subject to a 15-month freeze in Medicare reimbursement levels, Porter predicted that more sacrifices could be expected. "When we get down to the final moment of truth in the budgeting process. . . . in the past each side has said, 'Ok, You get your increase if I get mine,' and they pass the bill on to their children. This year, I think each side will have to take cuts instead. We can't continue to run up a big bill on our children's credit."

"We're in the middle of a revolution in health care and as part of it, government has changed the rules on reimbursement and prospective payment," he said. "I think, ultimately, we have to move toward a capitation system as a chance for the individual to make his or her choice on health care needs and spend his or her voucher in the medical marketplace."

Porter spoke of the skills and talents lost when physicians are forced to leave or restrict their practices due to the malpractice crisis. Calling for the support of the business community in forming coalitions for malpractice reform, he said, "This isn't an issue for doctors and lawyers. It's an issue for consumers in America. . . . it's something that must be addressed to assure that we have quality health care in America and not just defensive medicine."

Porter suggested that pending



Morgan M. Meyer, M.D., 1985-86 ISMS president, and his wife, Carol R. Meyer, M.D., after his inauguration.



Members of the 1985-86 ISMS Auxiliary Board.



Members of the ISMS Fifty Year Club enjoyed their annual luncheon and a presentation by Joseph Hinkamp, M.D., on preventive fitness. More than 140 physicians were honored as new members of the Fifty Year Club.



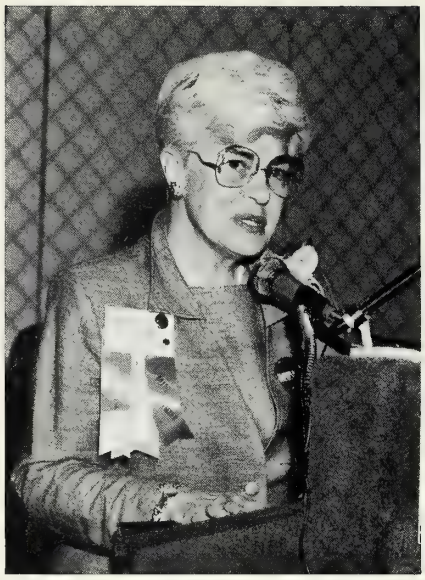
ISMS past presidents gather for the annual gourmet dinner. Those present (L-R) were Cyril C. Wiggishoff, M.D., Fred Z. White, M.D., Joseph H. Skom, M.D., Leo P.A. Sweeney, M.D., C.J. Jannings III, M.D., David S. Fox, M.D., George T. Wilkins, Jr., M.D., Robert P. Johnson, M.D., J.M. Ingalls, M.D., Newton DuPuy, M.D., J. Ernest Breed, M.D., Herschel Browns, M.D., Fredric D. Lake, M.D., P. John Seward, M.D., Frank J. Jirka, Jr., M.D., and Willard C. Scrivner, M.D.

federal legislation might help to bring pressure on the states to pass malpractice reform. Speaking in support of limits on noneconomic reimbursement and attorney contingency fees, he reminded the group that citizens can have an impact on legislation. "Public policy in America is made by the American people every day," he said. "If you want to change the medical malpractice climate, if you want to lessen the burden on our children, you can do it."

President's Valedictory

ISMS President Robert C. Hamilton, M.D., characterized his year as president as one focusing largely on the malpractice crisis. "I think it is pretty obvious in this case that we are all in it together and are putting 100% or more of our resources behind the professional liability initiative," he said. Referring to the impact on the cost of health care. "Basically, we're trying to do what we always have," he said. "We're trying to be sure we give the best quality health care to all our citizens."

"We doctors are a diverse group," he said. "What unites us is the need to deliver the best care to everybody regardless of their ability to pay or their method of payment."



ISMSA President Vivian Reardon reports on a year of legislative work, public education and fund raising for medical education.



Julian W. Buser, M.D., completes his term as Speaker of the House.

intense grass roots involvement, he added, "People who were never active before are now doing something about it. People who were never involved in issues at all are now conversant on legislation. I don't think I have to encourage anyone in this room or across the state to get involved, because I've never seen this level of involvement."

Dr. Hamilton discussed the widespread effects of malpractice, and

Illinois Governor James R. Thompson

Governor Thompson pointed out the importance of a solid public health program in attracting business and industry to the state. "Increasingly, companies looking to relocate are looking at housing, recreation, culture and medical care," he said. "As those that we call location insensitive companies grow, quality of life factors will become increasingly important."

"Quality medical care is most important to maintaining the state of Illinois as a world class medical center," he told the House. "It is increasingly important to our economic health. . . . and to making Illinois a good place to live, work and do business."

On professional liability, the Governor said, "The cost of malpractice to the state's doctors is entirely too high and something must be done at this session of the general assembly. The cost of malpractice to the people of Illinois is even higher, and something must be done for them. It's the people of this state who pay the bill," he continued. "Malpractice is an important component of the issue of quality medical care at the least available cost."

Governor Thompson introduced Bernard Turnock, M.D., newly appointed director of the Illinois Department of Public Health. He stated that he felt the appointment of an experienced epidemiologist would further his goals for the Department. The Governor told the House that Dr. Turnock, deputy director for the Chicago Department of Health, had worked for IDPH in emergency services,



Governor James R. Thompson (R) with his father, J. Robert Thompson, M.D. (L), Chicago, who is a member of the ISMS House of Delegates.

maternal and child health.

Dr. Turnock said that he would place emphasis on epidemiology and participation of local public health departments. Citing the recent Salmonella epidemic as an opportunity for enhanced local involvement, he called for local physician participation and early, regular reports of patient infections to public health departments. Dr. Turnock also pledged an enhanced role for the Medical Determination Board, and solicited the input of the ISMS membership as well.

President's Induction

Morgan M. Meyer, M.D., was inducted as 1985-86 president of ISMS at the closing session of the House on Saturday. Dr. Meyer's comments focused on change as a constant in medicine and the need to respond to social trends and needs.

"Ours is a proud profession," he told the House, "steeped in tradition and dedicated to the service of our fellow man and research in a scientific arena which has expanded in exponential fashion just within our lifetimes.

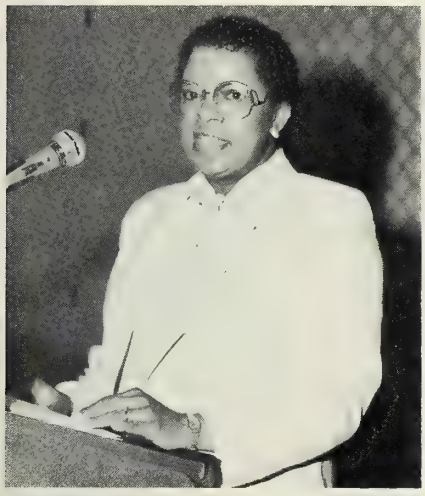
"In our present litigious society," he continued "the legal profession's public relations efforts over a very long period of time have made people feel that it is perfectly normal and acceptable for them to resort to the lawsuit as an appropriate vehicle to redress almost any perceived wrong. . . . This whole milieu, with the addition of the fantastic scientific advances and the extreme zeal with which the media exposes a new medical discovery to the public, even before it is readily available and practical for marketing, has brought the public to the point that their expectations are frequently outstripping the profession's ability to deliver a quality product or result on a consistent basis. . . . Unrealistic expectations must also be addressed in an honest and open way in order for us to help alleviate some of the root causes for our tremendous problem in the malpractice arena."

Dr. Meyer called for a major commitment to educate the public and reform tort law. "Now is the time for total professional cooperation and cohesive action to make the necessary and long overdue corrections which will, once again, enable us to practice better quality medicine in a kind and cost effective manner without the horrendous fear of legal financial annihilation," he told the House.

"Thank you for the honor of representing you. Please join me in our struggle to improve our profession and to preserve our free society." ◀



ISMS President Robert C. Hamilton, M.D., addresses the House of Delegtes. Dr. Hamilton was honored at the President's Night dinner dance featuring the Georgia Frances Orchestra.



Mrs. Anna Cannon, president, Illinois Society, American Association of Medical Assistants, tells of educational programs and membership promotion.



Cyril C. Wiggishoff, M.D., accepts plaque from ISMS President Robert C. Hamilton, M.D., at the conclusion of his term as IMPAC chairman. IMPAC membership grew to 4,396 over the last 12 months. IMPAC also received an award from AMPAC for the second highest increase in membership nationally. Members of the Illinois State Medical Society Political Action Committee celebrated IMPAC's 25th anniversary at a special reception with entertainment by political satirist William Mellberg.



ISMS Board of Trustees Chairman Alfred J. Clementi, M.D., addresses the House of Delegates. Dr. Clementi identified malpractice reform as a key issue, calling for an all out grass roots legislative effort. "We would like others to realize that malpractice is not bad doctors, it's a problem with the law," he told the House.

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People with a Purpose

By Suzanne Meirink/Belleville

The following is excerpted from the inaugural address presented before the ISMSA House of Delegates.

As we enter our 58th year of Auxiliary, we have witnessed great changes in society, in the practice of medicine and in the Auxiliary itself. We have become the forefront of social, political and medical issues. We have kept pace with the times. But, can you remember back, not too long ago, when your life was much simpler, much easier? When medical school tuition was a staggering $3,000 or $4,000 a year? When Medicare was only a gleam in Lyndon Johnson's eye? When doctors spent more time on house calls than in malpractice courtrooms?

What has happened over the years to make medical school a $20,000 or $30,000 annual drain? What has happened to Medicare so that it now consumes dozens of billions of dollars each year? What has happened to force doctors into spending so much time and energy defending their hard-earned professional credibility?

What has happened is *change*. And we as Auxiliary have a role to play.

Change in our world happens because human beings want change to happen. And if we don't like it, if we sit and complain about high tuition or government meddling or malpractice litigation, then we are *reacting* to change instead of *acting* to make change happen. If we don't rise up and shout and make our positions known on social issues or malpractice, then we are allowing others to change the world as they see fit, in their own image, without comment or suggestions from us. It is time for this organization to lead the way toward sensible change, sensible improvement of situations of lasting importance to us. We must keep working toward our goals.

The chosen profession of our spouses is under growing pressure. We face serious challenges in 1985 and beyond. We are under pressure from the media, from Washington, from state capitals, from bureaucratic meddlers who overspend taxpayer dollars and then raid a functional medical care system for the funds to cover their own enormous deficits.

Uncle Sam M.D. never went to medical school. Uncle Sam M.D. never paid $30,000 a year for education. Yet he wants to tell our doctors and nurses and hospitals not only how to administer medical care, but dictate who gets how much care and what kind, and which patient gets nothing.

We are people with a purpose, with the sense and sensitivity to alter a situation created of the government, by the government, and for the government. The escalating cost of medicine in America today is not the creation of doctors or hospitals. It is the work of an uncontrollable government urge to regulate, to administer, and to spend time, money, and resources on bureaucracy, not on health care improvements.

We will continue our own change with communication, action, and support. We will start with members of the media. We will explain to them the facts of medical life to counterbalance the public's media-bred impression that the medical fields are clogged only with insensitive doctors whose only goals in life are the accumulation of greenback dollars and 18 holes of golf every Wednesday.

As president of this Auxiliary, I intend to solicit the support of our members, and the support of future members, in a major public relations campaign to attract the media's interest in the bedrock realities it has ignored—dedication to human need, compassion for human life, and caring for the human existence. Our efforts will be recognized, and they will culminate in a statewide major media day

event early next spring. We will continue to stress the importance of maintaining quality medical care, and we will put forth our efforts to preserve the integrity and freedom of quality medical care for all. This is our mandate. This is our task. This is our purpose.

The same governmental bodies intruding upon efficient medical practices have ignored vast segments of our population in the greatest need of medical assistance. The elderly, who for the first time in the history of our nation now outnumber American teenagers, are ignored by the expedience of government economics. And we, the caring spouses of caring professionals, must join with others across the nation to prevent the complete elimination of quality care for the aged at the expense of misguided efforts to lower its cost. America's older people deserve the same quality in their homes, in their communities, in their institutions, that all Americans deserve, despite incessant attacks upon it.

Our young people, too, face crises that need our commitment to service. Child abuse began the day that Cain killed Abel. For it to continue so long is crime enough. No one truly knows how many American children suffer the torment of abuse each year. The figure we hear most often is one million. The facts of reality push that closer to 16 million.

Teen suicide has become a national epidemic, with a young person committing suicide every 90 minutes in America. Adolescence has always been a time of growth and painful adjustment. Is it surprising that so many teens of today find no future in a world that seems to hold no future? Many young people ask themselves, "Why should I continue to live when I already feel dead?" It's almost as if they've been through so much with drugs and alcohol and threats of annihilation that they feel "why not? What else is there?" So they find relief in the termination of their own young lives. We must speak loudly and act forcefully to eradicate the triggers of violence in our society, violence spawned by neglect, economic distress, and the weakness of our educational systems to prepare our youth for responsibilities of adulthood. This, too, is our purpose.

We will need help. We will need time, and the willing efforts of our members. But we must also look deeper into our ranks and increase our membership roles with people dedicated to service and the preservation of American medical professionalism against the onslaught of indifference. There will be more of us in the months ahead. We will seek them out. We will not be alone in our cause, our purpose.

We are the doctor's greatest ally. We are a public relations entity. Our message will be heard. Our concern for humanity will be witnessed. And our achievements for the medical profession will be recorded.

We will continue to strive to teach Americans preventive health measures that will reduce dependence upon medical service. Educational efforts must be undertaken to help people eliminate health risk caused by overindulgence in alcohol and tobacco, and underindulgence in physical activity. Continued Auxiliary diligence in support of medical scholarships is also needed. People with a purpose can engrave positive and lasting effects on these and our other goals.

Our voice will be clear. Our challenge will not be ignored. Our direction will be firm. The changes that we will carve from this point on will be in the correction of past inequities and for the better improvements of tomorrow. Our strength of purpose will lighten the burden of the senseless load on the back of today's medical professionals.

We, as the collective voice of the Auxiliary, can achieve these goals, if we decide now to pledge ourselves to the commitments we must uphold. Our message will show our concern for humanity as well as for the profession that tends to it.

We will counteract negative change, all of us, with our strength of belief that medicine—in the hands of qualified doctors, and in the hands of free enterprise—will forge even greater improvements in the quality of life for all Americans.

That is our challenge. That is our pledge. That is our guiding purpose. ◀

PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

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Internal Medicine—To join an active six member IM practice in mid-western university community. A sub-specialty in Rheumatology, Endocrinology, or Allergy is desirable, but not necessary. Contact: J. Buchanan, The Health Center, 702 N. East St., Bloomington 61701 (309-827-5051). (2)

BRADFORD:
Family physician wanted to take over 32 years of well established rural practice with office and house—reason retirement. 120 bed equipped hospital 20 minutes drive, 35 miles from major medical and educational center. Elementary and high school 2 blocks from home. Contact (309) 897-8181. (6)

FAIRFIELD:
Lucrative family practice Southern Illinois available, including office building, all equipment (x-ray, electrocardiogram, diathermy, three Birthcher's, Lab). Can accomodate two to three physicians. More information can be obtained by calling (618) 842-2187. (6)

FRANKFORT:
Multi-specialty group thirty miles southwest of Chicago seeks board elegible obstetrician-gynecologist to join expanding practice. Incentive plan, profit-sharing, relatively new building. Excellent practice opportunity with above average grade and high schools. Contact Howard Osmus, Administrator, Hedges Clinic, Frankfort, Il. 60423. (815-469-2123) (2)

KANE COUNTY:
Experienced occupational health physician needed to direct medical porgram in manufacturing plant in Southwest Suburbs. Call regional medical director (312)981-2195. (4)

ROCK ISLAND:
Internist group looking for a fourth physician to join growing area of Illinois Quad Cities. General internist and/or internist with sub-specialty willing to practice some general internal medicine. Offering financial guarantees and free rent for first year. Contact: Greg Romans, 2701 17th Street, Rock Island, IL 61201. (3)

SAYBROOK
Family practitioner—Excellent opportunity in east central Illinois; large modern office available; rural setting near modern well equipped community hospital; community is within twenty minutes of major universities, tertiary care centers; metropolitan area with major shopping, recreational and cultural activities available; financial incentives possible. Contact William Stack (309) 475-3521. (3)

VANDALIA
Specialists wanted. Family practice, internal medicine, pediatrics, general surgery, ENT, orthopedic surgery. One year guarantee with free office space. Needed for 92 bed acute, 134 bed LTC hospital in southern Illinois. Market covers 25,000+ people. Single office or clinic setting possible. Contact: Darrell Pile, Adm., Fayette Co. Hospital, Taylor Street, Vandalia, 62471 (618) 283-1231. (3)

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Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

JULY

Psychiatry

Special Marriage Enrichment
Symposium, July 13, 1985—1:00PM-6:00PM, Maywood, Illinois 60153. **Sponsor:** Loyola University Department of Psychiatry, 2160 South First Avenue, Room 3601, Maywood, IL. 60153. **Fee:** $30.00 per person. **Reg. Limit:** 60. **Credit:** Category 1: 5 hours; AAFP Elective: 5 hours. **Contact:** Domeena C. Renshaw, M.D. **Phone:** (312) 531-3752.

Emergency Medicine

Specialty Review in Emergency Medicine
For: Emergency Medicine Physicians. Lecture, July 29-August 3, 1985, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612 **Fee:** $590 per person. **Reg. Limit:** None. **Credit:** Category 1: 45 hours; **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649; outside Illinois phone (800) 621-4651.

5th Annual Common Emergency Care Problems
For: Health Professionals Managing Emergency Problems. Conference with workshops, July 17-18, 1985, Madison, Wisconsin. **Sponsor:** University of Wisconsin-Extension, Continuing Medical Education, 465b WARF Bldg.; 610 Walnut Street, Madison, WI 53705. **Fee:** $225 for physicians, $150 for nurses and others. **Reg. Limit:** None. **Credit:** Category 1: 12 hours; University of Wisconsin CEU's; American College of Emergency Physicians: 12 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Dermatology

Practical Office Dermatology
For: Internists, Pediatricians, General and Family Practioners. Lecture, July 15-19, 1985, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Fee:** $500. **Reg. Limit:** 90 **Credit:** Category 1: 37 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649; outside Illinois (800) 621-4651.

Obstetrics

High Risk Obstetrics
For: Obstetricians, OB-Gyn Residents and Fellows. Lecture, July 11-13, 1985, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Fee:** $280. **Reg. Limit:** 90. **Credit:** Category 1: 21 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649; outside Illinois: (800) 621-4651.

Pediatrics

Specialty Review in Pediatrics
For: Pediatricians. Lecture, July 22-28, 1985, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Fee:** $650. **Reg. Limit:** None. **Credit:** Category 1: 76 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649; outside Illinois: (800) 621-4651.

Urology

Urologic Oncology
For: Urologists, Oncologists, Pathologists. Lecture, July 22-25, 1985, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 South Wood Street, Chicago, IL 60612. **Fee:** $470. **Reg. Limit:** None. **Credit:** Category 1: 32 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649; outside Illinois: (800) 621-4651.

AUGUST

Surgery

Specialty Review in General Surgery, Part II
For: General and specializing surgeons. Lecture, August 19-30, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $750. **Reg. Limit:** None. **Credit:** Category 1: 100 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649; outside Illinois: (800) 621-4651.

Fiberoptic Esophagogastric Endoscopy
For: Surgeons, Internists and Gastroenterologists. Lecture, August 26-28, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $490. **Reg. Limit:** 15. **Credit:** Category 1: 16 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649; outside Illinois: (800) 621-4651.

Fiberoptic Colonoscopy
For: Surgeons, Internists, Gastroenterologists. Lecture, August 21-23, Chicago. **Speaker:** Herand Abcarian, M.D. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $490. **Reg. Limit:** 20. **Credit:** Category 1: 15 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649; outside Illinois: (800) 621-4651.

Pediatrics

Specialty Review in Neonatology/Perinatology
For: Pediatricians and Obstetricians. Lecture, August 26-30, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $610. **Reg. Limit:** None. **Credit:** Category 1: 53 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649; outside Illinois: (800) 621-4651.

Medicine

Specialty Review in Internal Medicine, Certifying
For: Internists and Medical Subspecialists. Lecture, August 4-10, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $650. **Reg. Limit:** None. **Credit:** Category 1: 74 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649; outside Illinois: (800) 621-4651.

SEPTEMBER

Emergency Care

Advanced Trauma Life Support Provider Course
For: Physicians, Emergency Personnel, Nurses, Course, September 11-12, 8:00 A.M.-5:00 P.M., Springfield. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $350. **Reg. Limit:** 20. **Credit:** Category 1: 16 hours. **Contact:** Charles E. Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** (217) 782-7711.

Geriatrics

Geriatrics
For: Physicians, other medical professionals. Symposium, September 14, 1:00-5:00 P.M. Lawrenceville, IL. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25.00. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Charles E. Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** (217) 782-7711.

Gynecology

Premenstrual Tension Syndrome
For: Physicians, other health professionals. Symposium, September 26, 1:00-5:20 P.M., DuQuoin, IL. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25.00. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Charles E. Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** (217) 782-7711.

Plastic Surgery

Plastic Surgery Nurses' Conference
For: Nurses, other health professionals. Conference, September 27, Springfield, IL. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25.00. **Reg. Limit:** None. **Credit:** 4 CEU's. **Contact:** Charles E. Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** (217) 782-7711.

Internal Medicine

Postgraduate Conference in Internal Medicine
For: Physicians. Symposium, September 26-27, 8:00 A.M.-5:00 P.M., Iowa City. **Sponsor:** University of Iowa College of Medicine, Continuing Medical Education, 285 Med Labs., Iowa City, IA 52242. **Fee:** $200. **Reg. Limit:** None. **Credit:** Category 1: 13 hours. **Contact:** R.M. Caplan, M.D. **Phone:** (319) 353-5763.

Rheumatology

Medical and Surgical Management of Arthritis
For: Practicing physicians. Seminar, September 13-20, St. Louis. **Sponsor:** Washington University School of Medicine, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $400. **Reg. Limit:** 50. Reg. Deadline: August 13. **Credit:** Category 1: 20 hours, AOA: 20 hours, AAFP Prescribed: 20 hours. **Contact:** Loretta Giacoletto, Administrative Coordinator. **Phone:** (800) 325-9862.

Infectious Disease

Infectious Disease Update
For: Physicians, other medical professionals. Symposium, September 12, 3:00-7:00 P.M. Quincy, IL. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25.00. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Charles E. Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** (217) 782-7711.

Cardiology/Nuclear Medicine/Radiology

10th Annual Nuclear Cardiology Symposium
For: Physicians in cardiology, radiology, and nuclear medicine. Symposium, September 18-20, Milwaukee, WI. **Co-Sponsors:** Cardiovascular Disease Program, Milwaukee Clinical Campus, School of Medicine, University of Wisconsin, 465B WARF Bldg.; 610 Walnut St., Madison, WI 53705. **Fee:** To Be Determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 20 hours; University of Wisconsin CEU's; voice credit—approx. 20 hours. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** (608) 263-2856.

1985 ICCME Congress
The Illinois Council on Continuing Medical Education (ICCME) is pleased to announce the Thirteenth Annual Congress on CME "Self-Directed Learning—The Gold Standard." The Congress is designed to provide the participants with the opportunity to explore various alternatives to traditional CME.

DATE: October 11-12, 1985

PLACE: Arlington Park Hilton, Arlington Heights, IL.

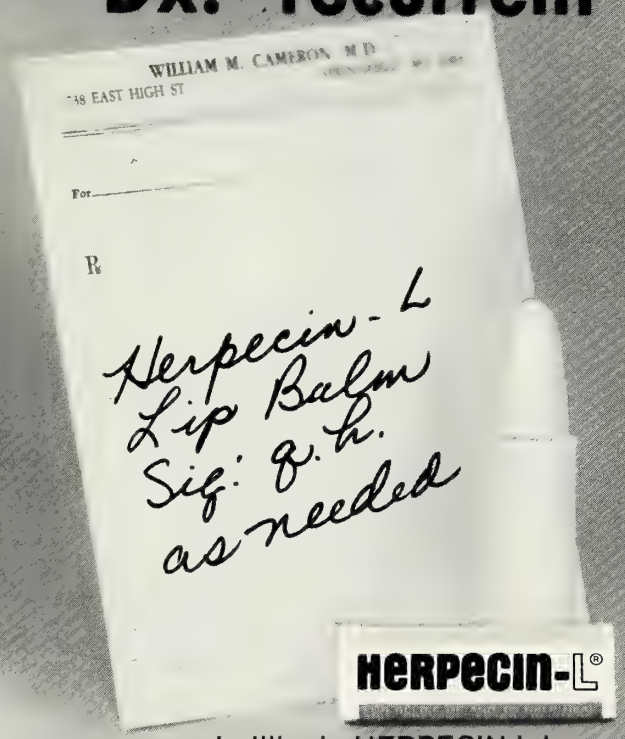
CME CREDIT: 9 hours of AMA Category 1

KEYNOTE SPEAKERS:
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Assistant Dean and Associate Professor
Michigan State University, College of Human Medicine
Executive Vice President, Grand Rapids Area Medical Education Center,
Grand Rapids, Michigan.

Alan B. Knox, Ph.D.
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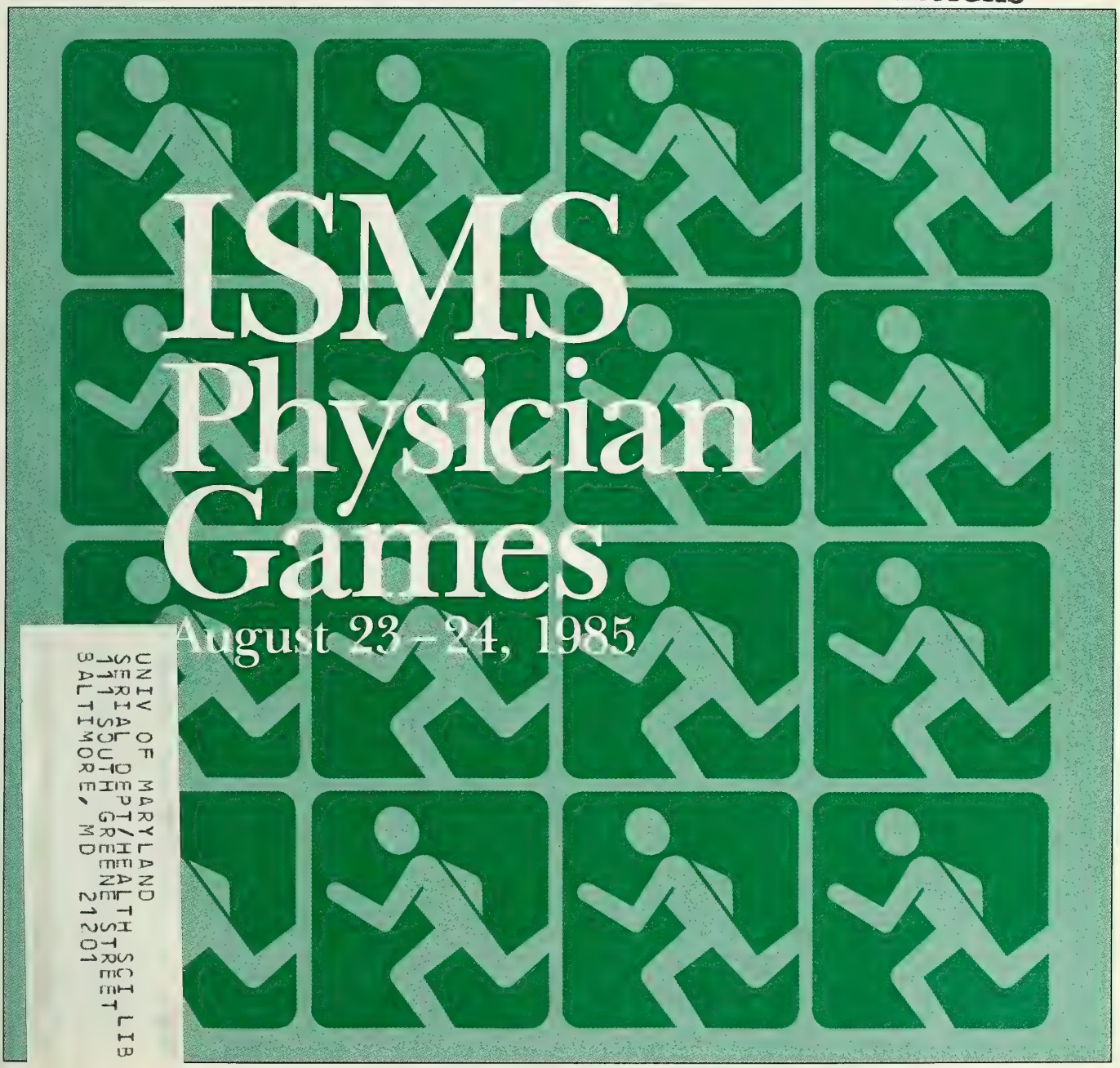
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Illinois Medical Journal
Illinois State Medical Society

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Privilege and Responsibility

During our recent professional liability initiative, continued questions arose concerning inadequacies in the medical disciplinary system. Many of these questions, of course, were brought up by members of the legal profession in their attempts to blunt the malpractice initiative. But some orginated with members of the news media genuinely concerned about the adequacy of the current system for dealing with complaints about physician behavior.

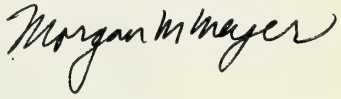
That the medical profession in Illinois wants effective physician discipline should be evident in our actions to date. Since the Illinois State Medical Society achieved passage of the Mandatory Reporting Act, actions against physicians have increased. In 1984, some 52 practitioners were disciplined, which represents an increase of 73% over the previous year.

This year, the Medical Disciplinary Board celebrates its 10th anniversary. An article authored by Dr. Helen Beiser and additional comments by Dr. Charles Wells appear elsewhere in this issue of *IMJ*. They present an intimate glimpse of the board's activities and the difficulties faced by those physicians who volunteered to serve the profession in this important role. We owe these physicians a debt of gratitude for giving a large portion of their time and energies to maintain the integrity of the medical profession in our state.

The Medical Disciplinary Board was created in 1972 when ISMS—following a membership survey which revealed strong support for an improved disciplinary system—drafted and vigorously pursued disciplinary legislation. That legislation ultimately was adopted in 1975 over the veto of then-governor Daniel Walker.

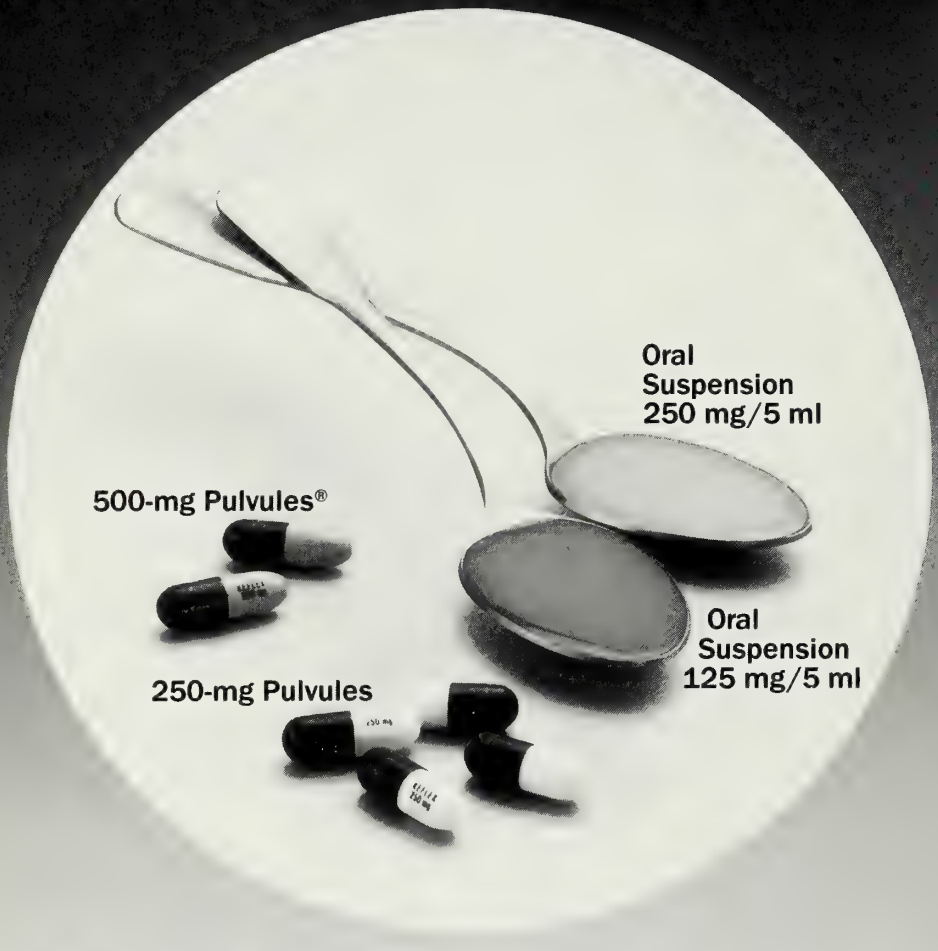
Since then, ISMS has sought to increase the disciplinary board's funding through increased license fees for physicians. The additional revenue helped bolster the investigational staff assigned to the Medical Disciplinary Board by the Department of Registration and Education.

The practice of medicine is still the most honored calling in our country and in our society. To be granted the privilege of helping and administering to our fellow man is undoubtedly the greatest honor that any profession can be granted. But with this privilege come considerable personal and group responsibilities. And the individual patient, his or her family, and society in general must be assured that our profession is committed to effective physician discipline. ◀



Morgan M. Meyer, M.D.
President

Easy To Take



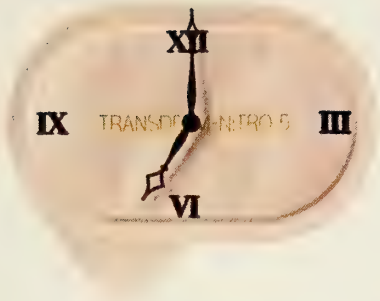
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Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

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In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

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Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.
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The usual dosage is one Transderm-Nitro 5 system every 24 hours. Some patients, however, may require the Transderm-Nitro 10 system. If a single Transderm-Nitro 5 system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 systems or one Transderm-Nitro 10 system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone.
The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.
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C I B A

MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P.,
CONTRIBUTING EDITOR

The tarsal tunnel syndrome is reviewed and a case presented with complaint of foot pain, paresthesia, and varying motor and vasomotor changes. This syndrome is a compression neuropathy at the medial aspect of the ankle where the tibial nerve enters the foot. The clinical impression may be confirmed by electromyography and nerve conduction studies comparing both feet, since this condition is generally unilateral. Surgical decompression offers good results in 80-90% of cases. (O'Malley, G., *et al., Orthopedics* 8:6, 758-60, June 1985)

Variable doses of physostigmine were administered to 12 patients with Alzheimer's disease every two hours for 3-5 days. Patient status was evaluated after each dose progressively from 0.0, 0.5, 1.0, 1.5, to 2.0mg. and the dose with the least severe symptoms was continued for 3-5 days. Ten patients completed the study. Three showed clinically significant improvement, four showed marginal improvement and three had inconsistent responses. Cortisol measurements showed that patients with best results had enhanced central cholinergic activity. (Mohs, R., *et al: Am J Psych* 142: 1, 28-33, Jan. 1985)

The optimal approach to the treatment of early breast cancer remains controversial. Ten year follow up studies in patients with stage I and II breast cancer appear to indicate similar results for radical as well as conservative surgical procedures followed by radiation therapy. (Danoff, B. *et al: Ann Int Med* 102:5,634-42, May 1985)

Osteoporosis does not appear to be a significant factor contributing to the incidence of hip fractures in the elderly. Bone mass is not contributory in predicting which patients are likely to have a hip fracture, since radiologic data show only minimal changes in bone mass in age compared groups with fractures and without. History of falling was more common in women with hip fractures. The fat content of the bone marrow, the accumulation of microscopic fractures, thin body habitus, cigarette smoking and alcoholism may be contributing factors. (Cummings, S.: *Am J Med* 78:3, 487-94, March 1985)

(Continued on page 52)

A Just Result

On June 25, 1985, Illinois Governor James R. Thompson signed into law House Bill 1604, a comprehensive reform measure designed to bring relief from the current malpractice crisis. The Governor's action was the culmination of months of intense activity by the state's physicians, who took their arguments for malpractice reform to the legislature, the media, and to the public in a massive "Professional Liability Initiative" organized by the Illinois State Medical Society.

It was the patients of the state's physicians who were the real winners when Gov. Thompson signed H.B. 1604 into law, according to Dr. Morgan M. Meyer, Illinois State Medical Society (ISMS) president. "Enactment of medical malpractice reform legislation will begin to restore balance in Illinois' civil justice system, while helping to assure the future availability of health care services at reasonable cost," Dr. Meyer said.

"The legislation signed by Gov. Thompson provides incentives for patients and physicians to move swiftly in settling medical negligence disputes," the ISMS president said. "It guarantees that a greater portion of award monies will reach truly injured parties. It weeds out waste—in time and dollars—which currently plagues our legal system. And it eases the way for those genuinely injured through malpractice to more promptly receive reasonable, long-term care."

Following the bill signing, Dr. Meyer expressed appreciation to lawmakers for responding positively to physician concerns. He also praised Gov. Thompson for his leadership.

"Through these efforts, Illinois has once again proven a leader in its willingness to search out remedies to critical public policy issues," Dr. Meyer said. "We hope this willingness persists as we work together in the future to improve the quality of health care and our state's legal climate."

Nonetheless, Dr. Meyer said the new legislation was only "a significant first step" toward correcting Illinois' medical malpractice legal climate. "We realize the job may not be complete without capping multi-million dollar pain and suffering awards," he emphasized. ISMS is prepared to address the General Assembly in two years to achieve additional needed reforms, according to Dr. Meyer.

Dr. Meyer attributed the medical profession's success to the tireless



Gov. Thompson poses for a photo after signing H.B. 1604. With the Governor (from left to right) are Drs. Fred Z. White, chairman of the Illinois State Medical Inter-Insurance Exchange Board of Governors; Morgan M. Meyer, president of the Illinois State Medical Society; and J. Robert Thompson, Gov. Thompson's father.

efforts of countless Illinois physicians. Signifying the depth of that physician concern and commitment was the May 22 Springfield rally when more than 4,000 physicians and supporters converged on the state Capitol to rally for malpractice reform legislation. Physicians flooded the Capitol and Stratton Office Building corridors seeking to meet with their senators and representatives. Later, brandishing signs, banners and placards, they filled the area in front of the Capitol, cheering as terms of an agreement with legislative leaders were announced.

The rally followed months of concerted local action by physicians. Working through "action teams" organized among hospital medical staffs and county medical societies, physicians worked diligently to convince the news media, general public, and ultimately, the members of the Illinois General Assembly, that reform of the state's medical malpractice laws was critically important.

The ISMS Professional Liability Initiative also has caused many physicians and auxilians to become active in the political process for the first time. ISMS urged physicians and their spouses to keep up that involvement at all levels—local, state and federal. The Society also was encouraging action teams to remain as a permanent mechanism within the hospital or county medical society. Action teams can keep abreast of the legislative and political scene, write or call legislators on topics of interest, lend support to friends of medicine in political races, and support the Illinois State Medical Society Political Action Committee.

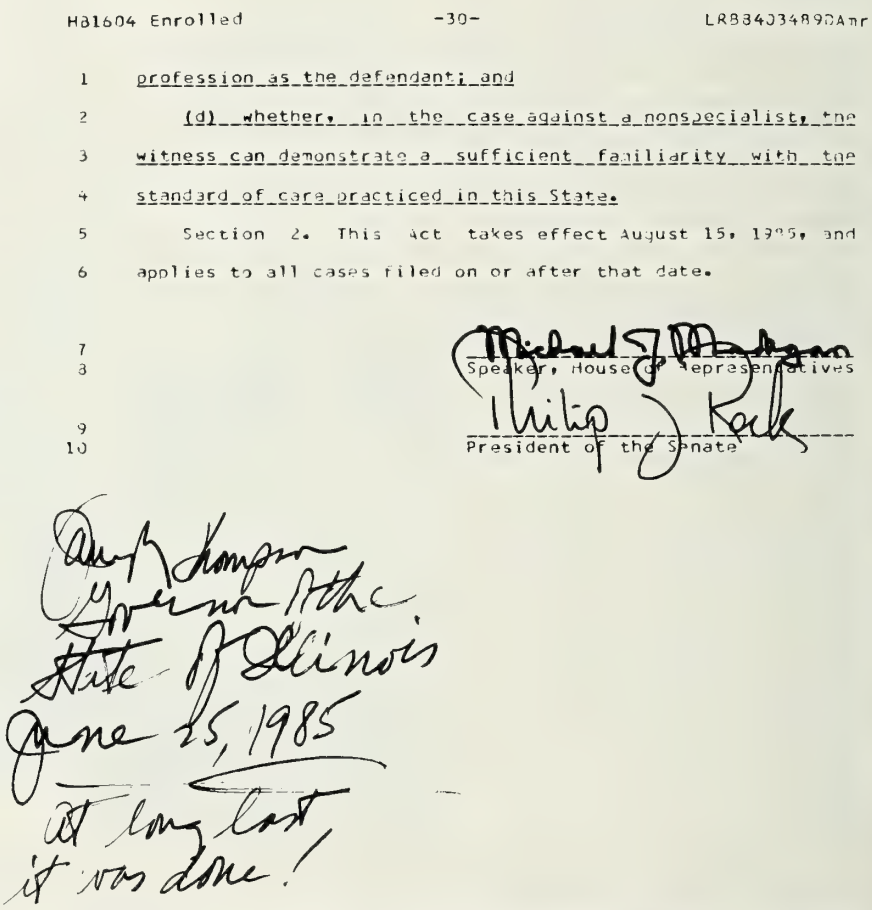
The passage of the legislation does not, however, mark the end of the quest for fairness in the handling of malpractice claims. Much needed caps on the size of malpractice awards were not part of the legislation, and physicians joined Dr. Meyer in vowing to return to Springfield to encourage the General Assembly to enact the remainder of the ISMS proposals. ◀

Scenes from the ISMS Legislative Rally for Malpractice Reform—Pictured on facing page (at top): Illinois Governor James R. Thompson addresses the 4,000 physicians who gathered on the Capitol lawn to rally for malpractice reform. The Governor was able to tell the assembly that an agreement in principle had been reached by the Senate and House leadership only minutes earlier.

First row (L-R)—One physician "lobbyist" suggests that those opposed to reform might "get a lawyer to deliver babies"—More than 70 buses were employed to bring physicians from throughout the state to Springfield—The throng of physicians outside the House and Senate chambers clamors for an audience with legislators within.

Second row (L-R)—Those legislators who were able to meet with physicians enjoyed an intensive dialogue—House Minority Leader Lee Daniels, who played a key role in mustering support for legislative reform, addresses the rally—ISMS President Morgan M. Meyer, M.D., briefs physicians before the trip to the Capitol.

Third row (L-R)—It was apparent that one of Illinois' most eloquent reformers, Stephen A. Douglas, would have supported the malpractice package—Four briefing sessions in a room holding 1200 persons were required to arm the 4,000 physician "lobbyists"—Senator Aldo DeAngelis (R-Chicago Heights) chief senate sponsor of the ISMS package, was among key legislative leaders addressing the rally.



HB1604 Enrolled -30- LRB8403489DAmr

profession as the defendant; and

(d) whether, in the case against a nonspecialist, the witness can demonstrate a sufficient familiarity with the standard of care practiced in this State.

Section 2. This Act takes effect August 15, 1985, and applies to all cases filed on or after that date.

Speaker, House of Representatives

President of the Senate

Gov. Thompson
Governor of the
State of Illinois
June 25, 1985
At long last
it was done!

Gov. Thompson's signature affixed on H.B. 1604 with the notation, "At long last it was done."

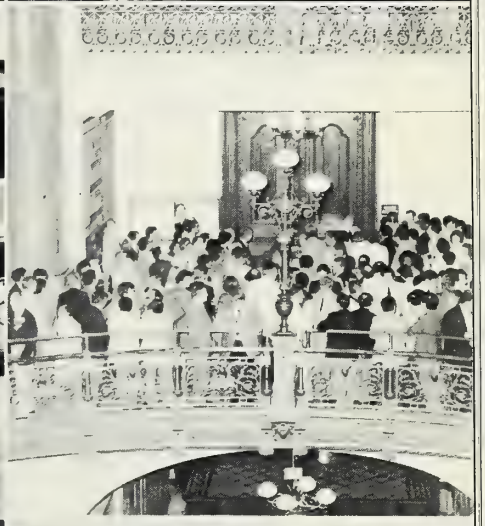








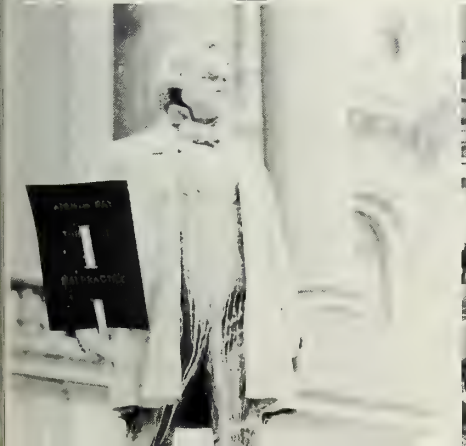

ISMS LEGISLATIVE RALLY








ISMS







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Once-daily INDERAL LA (propranolol HCl) for smooth blood pressure control without the potassium problems of diuretics

Once-daily INDERAL LA (propranolol HCl) avoids the risk of diuretic-induced ECG abnormalities due to hypokalemia.[1,2] In addition, INDERAL LA preserves potassium balance without additive agents or supplements while providing simple, well-tolerated therapy with broad cardiovascular benefits.

Once-daily INDERAL LA for the cardiovascular benefits of the world's leading beta blocker

Simply start with 80 mg once daily. Dosage may be increased to 120 mg to 160 mg once daily as needed to achieve additional control.

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

For beta-1/beta-2 blockade

Once-daily

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg

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Please see brief summary of prescribing information on the next page for further details.

Once-daily For beta-1/beta-2 blockade INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



The appearance of these capsules is a registered trademark of Ayerst Laboratories

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General.* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests. Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure, intensification of AV block; hypotension, paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

REFERENCES

1. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768. **2.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299.

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THE VIEWBOX

Contributing Editor Terrence C. Demos, M.D., Professor of Radiology, Department of Radiology, Loyola University Stritch School of Medicine

This month's Viewbox was contributed by Milton L. Paige, M.D. and Gary G. Ghahremani, M.D., Evanston Hospital-Northwestern University. Dr. Ghahremani, a board certified diagnostic radiologist, is professor and chairman of the department of diagnostic radiology. Dr. Paige, a board certified radiologist, is an assistant professor of radiology, Northwestern University Medical School and attending in radiology and pediatrics at Evanston Hospital.

An eight day-old male infant presented with intermittent nonbilious vomiting and abdominal distention. A radiograph was obtained shortly after introduction of 30ml of barium into the stomach through a nasogastric tube (Figure 1). A second radiograph taken 30 minutes later provided the correct preoperative diagnosis (Figure 2).



Figure 1
Initial radiograph following the introduction of 30ml of barium into the stomach reveals marked dilatation of the proximal duodenum.



Figure 2
Radiograph obtained 30 minutes later shows a thin, crescent-shaped filling defect at the junction of the first and second portions of the duodenum—a congenital mucosal diaphragm.

Your Diagnosis?

1. Annular pancreas.
2. Ladd's bands associated with midgut volvulus.
3. Congenital mucosal diaphragm.
4. Duodenal atresia.

(Continued on page 26)

Newly Formed Hospital Medical Staff Section

In an effort to enhance the hospital medical staff perspective in policy deliberations, the Illinois State Medical Society has created a new Hospital Medical Staff Section (HMSS). The section will be composed of one representative from each of the 274 hospital medical staffs identified by ISMS in Illinois. The section has been granted one delegate and alternate delegate in the ISMS House.

Medicine's changing socioeconomic environment prompted formation of the HMSS. The section is intended to help physicians practicing in hospitals meet the challenges of a changing environment, assess trends in hospital structure and management, and deal with the unique issues and problems that confront hospital medical staffs.

As envisioned by the ISMS House, the HMSS will have the following functions.

—Provide access for hospital medical staffs to the resources and policymaking apparatus of the ISMS;

—Provide a forum for hospital medical staffs to discuss common issues and concerns;

—Increase communication and awareness of hospital medical staff issues; and

—Enhance the relevancy of organized medicine to a greater number of physicians.

ISMS joins 21 other state medical societies who have established an HMSS. The Illinois section is expected to meet annually in conjunction with the ISMS annual meeting. There also are to be two section caucuses held in conjunction with the annual and interim meetings of the American Medical Association Hospital Medical Staff Section.

Representatives to the state HMSS are to be elected by their respective hospital staffs. Those elected must be part of the hospital's active staff and a member of ISMS.

To facilitate the operation of the HMSS, a governing council was elected at the June 15 HMSS caucus. Dr. Raymond A. Dieter, Jr., Glen Ellyn, was elected chairman. Other officers elected were: Drs. Joseph L. Murphy, Chicago, vice-chairman; Allan L. Goslin, Streator, secretary; and Thomas C. Malvar, Chicago, treasurer. At-large members of the governing council elected were: Drs. Warren D. Tuttle, Harrisburg; Lawrence A. Stone, Des Plaines; Albino T. Bismonte, Gurnee; and Jaroslav F. Neskodny, Berwyn. Dr. Silvana Y. Menendez, Belleville, was elected the section's delegate to the ISMS House, and Dr. Dennis M. Brown, Schaumburg, was named the alternate delegate.

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To qualify as an Air Force Flight Surgeon, you must:

* be a United States citizen.
* have completed one year of clinical postgraduate education, such as an internship or flexible postgraduate year.

APPLICATIONS ARE BEING ACCEPTED NOW

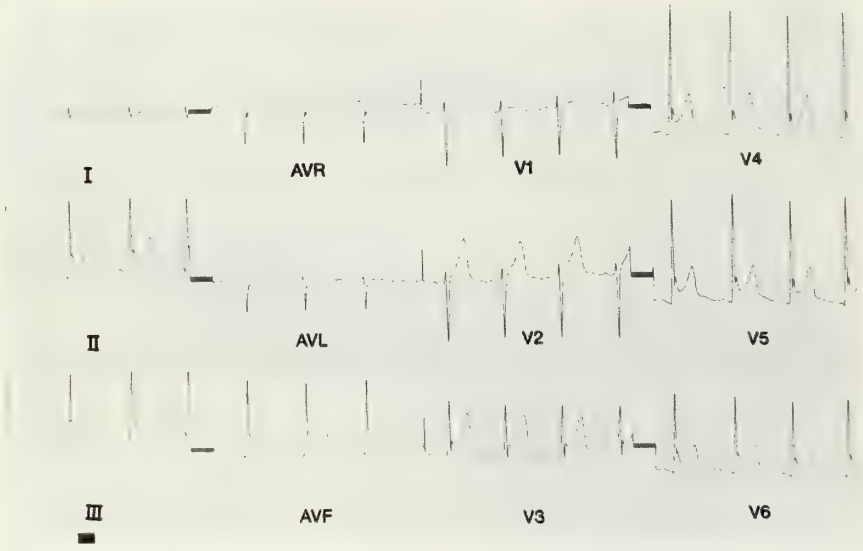
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EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This is a 27-year old man who was brought to the emergency room with a stab wound to the left anterior chest. Past medical history included much trauma due to involvement in street fighting. He had incurred fractures involving the right shoulder and clavicle, the left shoulder, the right knee, and an exploratory laparotomy with splenectomy. He admitted to cigarette smoking, as well as the use of alcohol, marijuana, cocaine, and heroin. Physical exam showed a blood pressure of 124/72mmHg, pulse 92/min, and the smell of alcohol on his breath. Examination of the heart was normal. Lungs were normal to ausculation. The bleeding stab wound was approximately one centimeter long in the seventh intercostal space and four centimeters lateral to the left sternal border. The abdomen was soft with normal bowel sounds but slightly tender in the left upper quadrant near the stab wound in the chest. A complete blood count was normal with a hemoglobin of 15.4 gms and an ethanol blood level was elevated. A chest x-ray, abdominal x-rays in four different views, and this 12 lead electrocardiogram were obtained.

Questions:

1. **The twelve lead electrocardiogram shows:**
 a. Left ventricular hypertrophy by QRS voltage.
 b. ST segment elevation compatible with a current of injury.
 c. ST segment elevation compatible with acute pericarditis.
 d. ST segment elevation compatible with an early repolarization and a normal variant.
 e. A and C only.

2. **A course of management of this patient could include:**
 a. An emergency thoracotomy.
 b. An emergency laparotomy.
 c. Admission to the hospital but only for observation.
 d. Serial electrocardiograms.
 e. All of the above.

(Continued on page 56)

ISMS Physician Games

The Physician Games have been organized by the Illinois State Medical Society Sports Medicine Committee, in cooperation with six Illinois medical centers. The Games will be held August 23-24, 1985 in Lincolnshire, Illinois.

The Physician Games offer an opportunity for sports-minded physicians and their spouses to participate in serious and friendly competitions and hear internationally recognized exercise science specialists. Participants will enjoy camaraderie over a two day period at the Marriott-Lincolnshire Resort Hotel in Lincolnshire, Illinois. Additionally, exclusive use of the off site courts has been arranged for tennis, racquetball and handball tournaments.

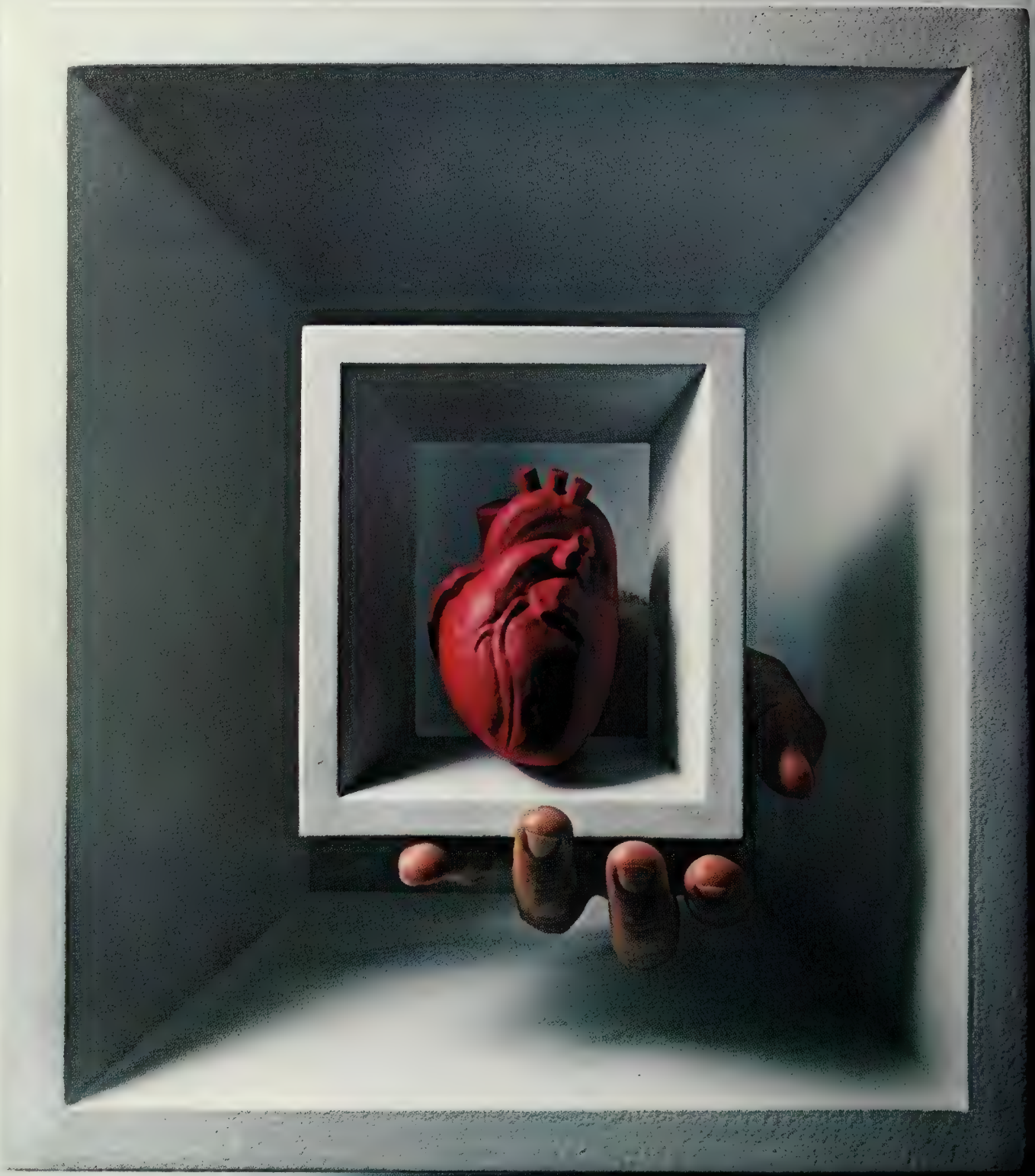
The Physician Games have been organized by the ISMS Sports Medicine Committee. Cosponsors include the Medical Center of Lake County, Rush-Presbyterian-St. Luke's Medical Center, Evanston Hospital, Northwestern Memorial Hospital, Westlake Hospital and Columbus Hospital. The ISMS and Lake County Medical Society Auxiliaries are also involved in this activity.

Highlights of the Physician Games include:

- Physician golf, tennis, racquetball and handball tournaments, a 5000 meter run, a 400 meter swim and a martial arts demonstration;
- An exercise science program offering keynote presentations by internationally recognized speakers. Per Olof Astrand, M.D., of the Karolinska institute, Stockholm, will discuss, "Physiology of the Mature Athlete." William Castelli, M.D., of the Framingham Heart Institute in Boston, will present, "Implications of Life-Long Exercise."
- An exciting Spouses' Program is planned, involving golf, tennis and racquetball tournaments, a 3000 meter run, a 200 meter swim, aerobic dance classes and motivating lectures for active women. *Women's Sport and Fitness Magazine* and the Dairy and Nutrition Council, Inc., will co-sponsor this program, which will include the appearance of Ralph Nelson, M.D., nutrition editor, *Physician and Sportsmedicine Magazine.*
- A volleyball tournament for competing teams from hospitals, medical schools, clinics and medical societies;
- Bridge and chess tournaments;
- Messages to the physician participants from Sir Roger Bannister, M.D., St. Mary's Hospital, London, England, and Peter Ueberroth, past president, Los Angeles Olympic Organizing Committee and current commissioner of baseball;
- A cocktail reception and festive awards banquet.

The Physician Games are made possible by grants from the following corporations: Abbott Laboratories; Ciba-Geigy Pharmaceuticals; Lederle Laboratories; NutraSweet Group, G.D. Searle & Co.; SAS Airlines; Smith Kline & French Laboratories; and Syntex Laboratories.

For further information, or to register, contact the Division of Medical Services, ISMS, Twenty North Michigan Ave., Suite 700, Chicago IL 60602 or call 1-312-782-1654. ◀



Angina Protection with Benefits for a Lifetime

ONCE-DAILY CONTROL WITH HEART-SAVING BENEFITS

By reducing heart rate and cardiac contractility, INDERAL LA helps protect the heart from the potentially serious and debilitating consequences of ischemia. A highly effective antianginal agent for around-the-clock control of symptoms, INDERAL LA also provides cardiovascular protection for a sense of security in the years ahead.

PROTECTION AND EXPERIENCE NO CALCIUM BLOCKER CAN MATCH

Unlike calcium blockers, INDERAL LA—either alone or with a nitrate—is recommended for early treatment of angina in the majority of patients. Equally important, INDERAL LA delivers the proven performance and safety profile of INDERAL tablets—confirmed by millions of patients during 16 years of clinical use.

START WITH 80 MG ONCE DAILY

Dosage may be increased to 160 mg once daily, as needed, to achieve optimal control. INDERAL LA should not be used in congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma. Please see next page for further details and brief summary of prescribing information.

ONCE-DAILY **INDERAL LA** (PROPRANOLOL HCl) LONG ACTING CAPSULES



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JUST ONCE EACH DAY FOR SIMPLIFIED CORE THERAPY IN ANGINA

ONCE-DAILY INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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The High Price of Dedication

By N. Mark Bates/Maywood

The recent malpractice rally in Springfield was an excellent example of how hard physicians must work just to be able to practice medicine. Delivering health care in this era of government intervention is difficult enough without worrying about debilitating malpractice insurance payments.

Medical students are also being rudely introduced to the new era of medicine by their struggle to finance an expensive medical education. They, too, are finding themselves caught between rising costs and limited resources. More and more students are faced with a choice between incurring massive debt or giving up the profession they have struggled to enter. Just as the malpractice situation in Illinois required immediate attention and action, the economic plight of new and continuing students is one of concern.

The problem of educational financing can be divided into two categories. The first is consideration of the total indebtedness with which a typical student graduates. At Loyola Stritch School of Medicine, where costs are about the median of all Illinois medical schools, the average state resident student must anticipate spending $80,000 for his/her last four years. Unfortunately, many students will have already become indebted for their undergraduate education; their start into the medical profession may be burdened with over $100,000 in overhead.

The second area of concern for students is one of very recent origin. It is becoming increasing difficult to borrow enough money to become a doctor. The federal and state governments have been the major source of educational loans for many years. These programs have been providing up to 85% of the typical student's total budget. Now, however, the political winds have changed and support for physicians, whether in practice or in training, is no longer popular or a priority.

Many of the loan programs currently in existence are being targeted for heavy cuts by the Reagan administration. The major loan program sponsored by Illinois, the IIHELA, will be in its last year of funding in the next school year. Not only will loans be more difficult to get but they will become prohibitively expensive. The interest rates may be as low as 5% but for the federal HEAL loan, which provides much of many students' total budgets, the rate is now 12% and has been as high as 18%.

It is imperative that this financial crisis be addressed and attacked by several means. The most important way is to make more physicians and legislators aware of this situation. Political pressure must be used to maintain current loan programs at the current level if they cannot be expanded. Collection on current defaulted educational loans should be endorsed to return more money to be re-loaned and to counteract much bad publicity. And finally, there should be no non-paid residency and fellowship positions.

The effort to resolve the medical education crisis is much like malpractice reform; the battle is just beginning. ◀

Obituaries

Brubaker, Harold S., Tampa, Florida (formerly of Lanark), died April 1, 1985 at the age of 82. Dr. Brubaker was a graduate of the Loyola University Stritch School of Medicine, Maywood.

***Buckley, Joseph H.,** Evergreen Park, died May 19, 1985 at the age of 72. Dr. Buckley was a 1940 graduate of the University of Illinois College of Medicine, Chicago.

Butler, Earley Jr., Chicago, died May 8, 1985 at the age of 54. Dr. Butler was a 1965 graduate of MeHarry Medical School of Medicine, Nashville, Tennessee.

Clark, Clayton N., Oak Park, died March 26, 1985 at the age of 96. Dr. Clark was a graduate of the Kirksville College of Osteopathy and Surgery, Kirksville, Missouri.

****Cotell, Harry,** Monterey, California, died May 26, 1985 at the age of 79. Dr. Cotell was a 1932 graduate of the Loyola University Stritch School of Medicine, Maywood.

****Evans, Joseph P.,** Kensington, Maryland, died May 8, 1985 at the age of 80. Dr. Evans was a 1929 graduate of Harvard Medical School.

Grochowsky, John, Chicago, died May 11, 1985 at the age of 69. Dr. Grochowsky was a 1955 graduate of a German medical school.

****Hall, Marshall W.,** Mt. Vernon, died May 1, 1984 at the age of 88. Dr. Hall was a 1924 graduate of the St. Louis University School of Medicine, St Louis, Missouri.

***Hand, William J.,** Michigan City, Indiana, died May 21, 1985 at the age of 64. Dr. Hand was a 1943 graduate of the University of Chicago Pritzker School of Medicine.

Heck, Charles V., Oak Park, died May 8, 1985 at the age of 66. Dr. Heck was a 1943 graduate of the University of Illinois College of Medicine, Chicago.

****Herz, Fritz,** Elmhurst, died April 13, 1985 at the age of 89. Dr. Herz was a 1922 graduate of Medizinische Fakultat der Julius-Maximiliams-Universitat, Wurzburg, Bayern, Germany.

***Karraker, Richard W.,** Moline, died April 25, 1985 at the age of 67. Dr. Karraker was a 1942 graduate of the University of Illinois College of Medicine, Chicago.

***Mehta, Ramesh L.,** Chicago, died April 28, 1985 at the age of 48. Dr. Mehta was a 1964 graduate of the University of Bombay, India.

****Roberson, Wm. Victor,** Wood River, died April 15, 1985 at the age of 74. Dr. Roberson was a 1935 graduate of the University of Illinois College of Medicine, Chicago.

***Saxon, Michael R.,** Naples, Florida (formerly of Aurora), died April 18, 1985 at the age of 74. Dr. Saxon was a 1936 graduate of the Northwestern University Medical School, Chicago.

***Smith, T. Manuel,** Chicago, died May 21, 1985 at the age of 93. Dr. Smith was a 1915 graduate of MeHarry Medical College School of Medicine, Nashville, Tennessee.

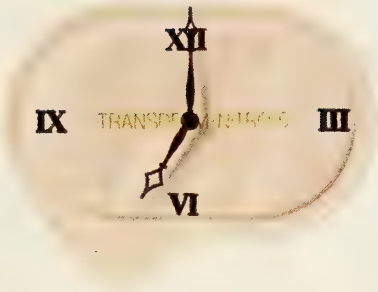
***Standard, John V.,** Springfield, died May 8, 1985 at the age of 60. Dr. Standard was a 1951 graduate of the Northwestern University Medical School, Chicago.

***Thomas, Andrew L.,** Chicago, died May 15, 1985 at the age of 52. Dr. Thomas was a 1961 graduate of the Howard University College of Medicine, Washington, D.C.

****Wakefield, Howard,** Somis, California (formerly of Chicago), died March 20, 1985 at the age of 92. Dr. Wakefield was a 1925 graduate of Rush Medical College, Chicago.

Williams, Jasper F., Chicago, died April 15, 1985 at the age of 67. Dr. Williams was a 1953 graduate of the Creighton University School of Medicine, Omaha, Nebraska.

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INDICATIONS AND USAGE
This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.
Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea, vomiting, and dermatitis. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued.

DOSAGE AND ADMINISTRATION
Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.
The usual dosage is one Transderm-Nitro 5 system every 24 hours. Some patients, however, may require the Transderm-Nitro 10 system. If a single Transderm-Nitro 5 system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 systems or one Transderm-Nitro 10 system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone
The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs
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PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

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10 mg/24 hr	50 mg	20 cm^2	30 Systems (NDC 0083-2110-26) *100 Systems (NDC 0083-2110-30)
15 mg/24 hr	75 mg	30 cm^2	30 Systems (NDC 0083-2115-26) *100 Systems (NDC 0083-2115-30)

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Viewbox

(Continued from page 15)

Diagnosis: Incomplete Duodenal Obstruction Due to Congenital Mucosal Diaphragm

The first radiograph demonstrates marked dilatation of the first portion of the duodenum with delayed passage of barium distally. Due to nasogastric suction, the stomach appears normal in size with a widely patent pyloric channel. The differential diagnosis at this point consists of annular pancreas, duodenal atresia or stenosis, and Ladd's bands associated with midgut malrotation. However, the second radiograph, taken 30 minutes later, shows the normal position of duodenal loop and the ligament of Treitz. Furthermore, it outlines a thin, crescent-shaped defect at the junction of first and second duodenal segments. Retained intestinal contents or meconium are seen as filling defects within the distal duodenum and proximal jejunum.

At surgery, the second portion of duodenum was almost totally blocked by a mucosal diaphragm which was 3mm thick and contained a 2mm eccentric opening. This diaphragm, located just proximal to the ampulla of Vater, was excised without difficulty and the patient made an uneventful recovery.

A congenital duodenal diaphragm is composed of a double layer of duodenal mucosa covering a fibromuscular core forming a thin intraluminal septum. This anomaly represents a disruption in the embryologic process of recanalization of the primitive foregut lumen. The incidence is reported to be one in 9,000 to 40,000 births.[1] Frequent association with other anomalies such as annular pancreas, midgut malrotation, congenital heart disease, Down's syndrome, imperforate anus, Hirschsprung's disease, omphalocele and hypoplastic kidneys have been described.[2,3] Most duodenal diaphragms with a small central opening manifest obstructive symptoms soon after birth, permitting early recognition and surgical treatment. An incomplete mucosal septum containing a relatively large aperture or fenestration, however, may remain clinically silent or cause mild postprandial discomfort during early childhood. In such instances, the duodenal diaphragm may gradually transform into a pulsion-type intraluminal diverticulum due to continuous stretching by the forces of peristalsis and duodenal content. Upper gastrointestinal examination will then show a pear-shaped pouch resembling a barium-filled wind sock, partially obstructing the duodenal lumen.[4] ◀

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Vascular Pathology

By Eugene J. Rogers, M.D. and Robert J. Rogers, M.D./North Chicago and Los Angeles

Atherosclerotic vascular changes can involve vessels to the brain, heart, kidneys, and extremities. Our study evaluated the supraorbital, carotid and tibial pulses with a Doppler flow meter and reviewed the EKG reports on 21 hospitalized patients. The diagnoses were diabetes mellitus, hypertension, peripheral vascular disease, amputation, cerebrovascular accident and/or cardiac pathology. The data on 10 CVA patients showed diminished reflected Doppler amplitudes in the ipsilateral supraorbital and carotid arteries and decreased amplitudes in the hemiplegic tibial artery. Seven of these patients also showed EKG abnormalities. The incidence of diminished amplitudes recorded was higher in those patients with electrocardiographic abnormalities, those with histories of hypertension, and those with peripheral vascular disease. Individuals with atherosclerosis and local vascular problems thus warrant a comprehensive approach in evaluation and treatment for systemic vascular disease.

This preliminary study evaluated the vascular status in 21 hospitalized patients. The diagnoses at time of admission were cerebrovascular accident, peripheral vascular disease, amputation, diabetes mellitus, hypertension and/or myocardial insufficiency. A Doppler ultrasonic flow meter was used to measure the blood flow in both supraorbital, both carotid and in both posterior tibial arteries. The EKG evaluated cardiac status. Patients presenting with symptoms of localized vascular lesions were thus evaluated for the presence of other vascular involvements.

A localized degenerative vascular process could similarly afflict critical vessels to a variable degree in the brain, heart, kidneys and extremities.[1] These processes are dynamic with progression and regressions, and can be evaluated by ultrasonic studies.[2] The Doppler ultrasonic flow meter is a non-invasive helpful technique for diagnosing chronic occlusive arterial disorders and in localizing sites of partial or complete occlusions.[3] McDonald, *et al*,[4] reported 74% overall accuracy with the Doppler non-invasive technique when 60% of the lumen of the internal carotid was occluded as measured by angiography. This non-invasive procedure may assist in the ultimate decision for angiography in asymptomatic patients.[5]

Our findings suggest that patients presenting with localized vascular syndromes may similarly exhibit asymptomatic vascular disease in other areas. Occlusive arterial disease has been reported in 55% of 100 patients with acute myocardial infarction and conversely, severe coronary disease is related directly to the severity of the peripheral occlusive arterial disease even in asymptomatic patients.[6] We reiterate the necessity of a comprehensive evaluation and treatment program in patients with symptoms of only a localized degenerative vascular process. Patients with localized vascular syndrome should be periodically reevaluated for progression to other occlusive vascular syndromes.

Method

Twenty-one patients admitted to the rehabilitation ward were evalu-

Table 1A
Major Diagnoses

Mean Age	MI/ ASHD	History Hyperten.	CVA
60.7	12	11	10

Amputation	Diabetes Mellitus	PVD (No Amp.)
6	5	3

Table I

Age	Pulse	B.P.	Dx-Other	CVA	Diab. Mell.	Hypert. History	MI or ASHD	Per. Vasc.	LT. Supra-orb.	RT. Supra-orb.	LT. CAROT.	RT. CAROT.	LT. P. TIB.	RT. P. TIB.
69	72	140/80		—	X	X	X	X (Rt AK)	.8 cm	.7 cm	2.6 cm	2.2 cm	1.8 cm	—
72	100	110/68	Hip Fract, COPD Alcoholism				X		—	—	2.6 cm	1.8 cm	1.0 cm	.6 cm
87	84	110/70	Angina, AV Block				X		.4 cm	.9 cm	2.6 cm	2.7 cm	1.3 cm	.9 cm
62	80	100/70	Cirrh., Ren. Fail.				X		—	—	2.8 cm	2.0 cm	1.4 cm	1.6 cm
34	76-80		Alcoholism						.2 cm	.4 cm	2.1 cm	2.0 cm	1.3 cm	1.6 cm
64	88	126/80	Lt. Carotid Endarter			X		X (Rt AK)	.5 cm	.5 cm	2.7 cm	2.7 cm	1.2 cm	—
57	88-92	140/80	Rheum. Arth.			X		X (Lt BK)	1.0 cm	1.0 cm	1.7 cm	1.9 cm	—	.6 cm
61	80	134/90				X	X	X (Lt AK)	.8 cm	1.0 cm	2.0 cm	2.6 cm	—	1.0 cm
63	76	110/70						X (Lt AK)	.5 cm	.7 cm	2.5 cm	2.5 cm	—	3.0 cm
57	76	140/80	Cerebellar ataxia Alcoh., COPD			X	X		.6 cm	.7 cm	1.7 cm	2.3 cm	2.1 cm	2.0 cm
85	88	90/60	Lt. Hip Fract.						.6 cm	1.3 cm	2.6 cm	2.8 cm	2.7 cm	1.9 cm
51	76	125/80	Rt. Hemipl.	LT					—	.5 cm	2.8 cm	2.7 cm	1.8 cm	1.0 cm
57	92-96	100/80	Rt. Hemipl.	LT	X				.6 cm	.9 cm	2.3 cm	2.6 cm	1.0 cm	1.5 cm
58	104	148/90	Lt. Hemipl.	RT		X	X	X (Rt AK)	1.0 cm	1.0 cm	1.7 cm	2.3 cm	.7 cm	—
45	100	110/70	Lt. Hemipl.	RT	X		X	X	.2 cm	.8 cm	2.0 cm	2.3 cm	2.0 cm	2.5 cm
63	68	132/76	Rt. Hemipl.	LT	X	X	X		.9 cm	.5 cm	2.2 cm	3.0 cm	1.9 cm	2.0 cm
56	84	110/80	Lt. Hemipl.	RT	X	X	X		.9 cm	.8 cm	2.6 cm	2.6 cm	1.0 cm	1.0 cm
59	68	130/96	Hydroceph.	RT		X	X	X	.1 cm	.2 cm	2.2 cm	2.0 cm	.6 cm	.4 cm
58	72	120/76	Aortoiliac Endart.	LT		X	X	X	.8 cm	1.2 cm	1.7 cm	2.2 cm	2.5 cm	1.4 cm
53	72	140/100	Alcoholism	RT		X			.5 cm	.5 cm	2.5 cm	1.5 cm	1.5 cm	2.6 cm
65	84	140/70	Alcoholism	RT					1.6 cm	.2 cm	2.7 cm	1.7 cm	1.0 cm	.7 cm
60.7							MEAN		.57 cm	.657	2.31 cm	2.3 cm	1.28 cm	1.25 cm
34-87							RANGE		.1-1.6 cm	.2-1.	1.7-2.8	1.5-3.0	.6-2.7	.4-3.0

ated with the Doppler ultrasonic flow meter. All were male patients 34 to 87 years of age and their admitting diagnoses were cerebrovascular accident, diabetes mellitus, peripheral vascular disease, chronic pulmonary disease, cardiac manifestations of hypertension and/or myocardial insufficiency and/or alcoholism.

The data recorded was age, pulse rate, blood pressure, diagnoses, and the EKG report. The ultrasonic head was placed bilaterally in similar locations at the same 45° angle over the supraorbital, carotid and tibial pulses. The posterior tibial artery was chosen rather than the dorsalis pedis artery since a Mayo Clinic study had shown that only one of the 248 normal individuals had an abnormal posterior tibial pulse, whereas 10% of normal had

Table 2
Values For the 21 Patients

Lt. Supra Orbital	Rt. Supra Orbital	Left Carotid	Right Carotid	Left Tibial	Right Tibial	
.57	.657	2.32	2.3	1.28	1.25	Mean
.1-1.6	.2-1.3	1.7-2.8	1.5-3.0	.6-2.7	.4-3.0	Range of Values

The amplitudes of the reflected ultrasonic waves in centimeters revealed these mean values for the 21 patients.

Table 3
Values For Left CVA Patients

Lt. Supra Orbital	Rt. Supra Orbital	Left Carotid	Right Carotid	Left Tibial	Right Tibial	
—	.5	2.8	2.7	1.8	1.0	
.6	.9	2.3	2.6	1.0	1.5	
.9	.5	2.2	3.0	1.9	2.0	
.8	1.2	1.7	2.2	2.5	1.4	
.76	.775	2.25	2.6	1.8	1.47	Mean

The four patients with a left CVA and right hemiplegia exhibited a lower mean in the left carotid pulses than the right and concurrently lower tibial vessel amplitudes on the hemiplegic side.

impaired dorsalis pedis pulses.[7] Limbs were maintained in the horizontal position. The recorder was set at a constant speed of 5mm/second, amplification kept constant and peaks recorded as centimeters from the baseline.

The Doppler flow meter emits ultrasonic waves at a predetermined frequency and measures reflected waves of different frequencies. This variation in the reflected ultrasonic waves grossly correlates with the volume of blood flowing through the blood vessel overlying the ultrasonic head. The tracings of the reflected ultrasonic waves from both supraorbital, both carotid, and both posterior tibial vessels were compared. These recordings were done successively and variations in the angle of the ultrasonic head to the blood flow and the locations over the blood vessels were kept bilaterally equal. We hoped to obtain reliable comparisons as to the Doppler reflections from each of the matched blood vessels. The blood flow through matched blood vessels was compared by measuring the amplitude of the reflected waves at time of systole.

The data compared the mean amplitudes measured in centimeters for each of the paired blood vessels. The standard deviation was subtracted from the mean and those values below this low range were then considered for the various clinical entities. The small number of cases precludes a statistically significant conclusion but suggests the merits of a more comprehensive evaluation process in patients with localized degenerative vascular symptoms.

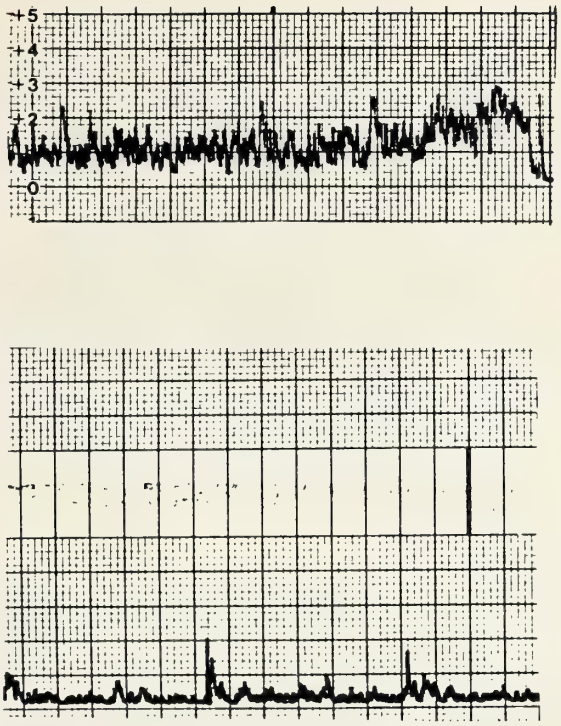


Figure 1
Case #20,53 Yr Old, Left Hemiplegia
Superior orbital artery Doppler tracings in hemiplegic patient.

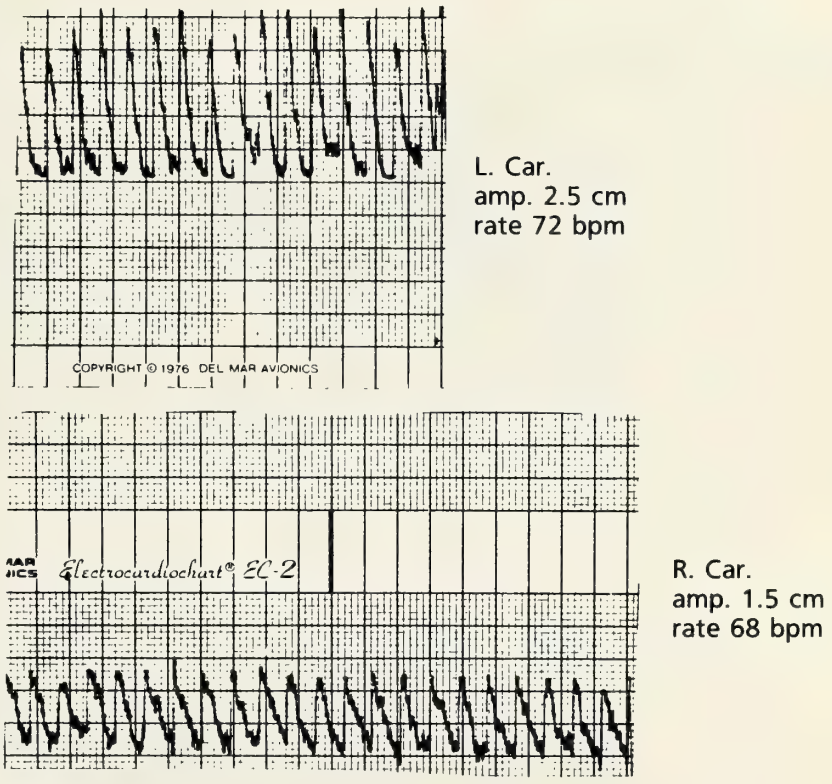


Figure 2
Case #20, 53 Yr Old, Left Hemiplegia
Carotid artery Doppler tracings in hemiplegic patient.

Results

Results are summarized in Tables 2-8 and Figures 1-3.

Discussion

The vascular tree permeates all living tissues. A systemic vascular pathologic process, such as arteriosclerosis, could thus impair various organs. The medical literature reports that acute stroke may predispose victims to cardiac problems[8] and coronary arteriosclerosis was found in 75% of patients with cerebrovascular accidents.[9] Hyperten-

sive patients are reported to have increased risks of atherosclerosis and 38% of arteriosclerotic patients required anti-hypertensive therapy.[10] Patients with atherosclerotic occlusive disease had coronary heart disease in 30% of cases. Sixty percent of patients with peripheral arteriosclerotic occlusive vascular disease had abnormal posterior tibial Doppler results.[11] Only 8% of diabetic patients had abnormal posterior pulses on the Doppler flow meter, yet 22% showed peripheral vascular disease clinically.[11] Coronary artery disease frequently coexists with peripheral occlusive arterial disease, possibly altering the therapeutic regimen. Spittel reports that in 100 cases admitted for acute MI, 55 patients showed peripheral vascular disease.[6] Occlusive tendencies in coronary vessels of males could similarly afflict their cerebral vessels on the basis of inherited thromboembolic predisposition.[12] Patients with peripheral vascular disease often have overt or subclinical heart and cerebrovascular disease thus warranting EKG

Table 4
Right CVA With Left Hemiplegia

Lt. Supra Orbital	Rt. Supra Orbital	Left Carotid	Right Carotid	Left Tibial	Right Tibial	
1.0	1.0	1.7	2.3	.7	—	
.2	.8	2.0	2.3	2.0	2.5	
.9	.8	2.6	2.6	1.0	1.0	
.1	.2	2.2	2.0	.6	.4	
.5	.5	2.5	1.5	1.5	2.6	
1.6	.2	2.7	1.7	1.0	.7	
.71	.58	2.2	2.0	2.2	1.4	Mean

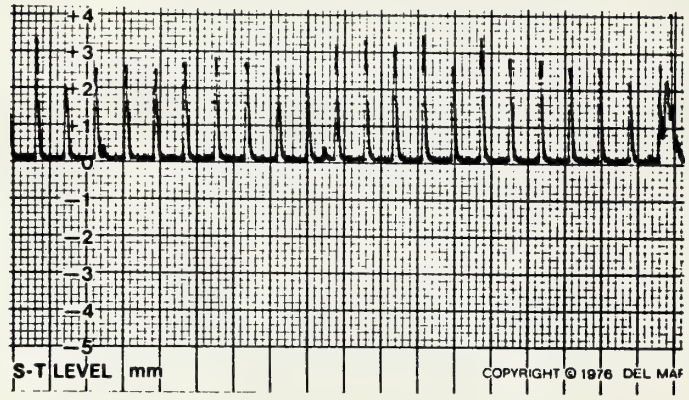
Patients with a right CVA and left hemiplegia similarly exhibited lower mean wave amplitudes in the right supraorbital and right carotid blood vessels. The tibial vessel in the hemiplegic extremities showed lower amplitudes than the uninvolved extremity.

Table 5
Ipsilateral Head Vessel and Contralateral Extremity Vessel Impairments

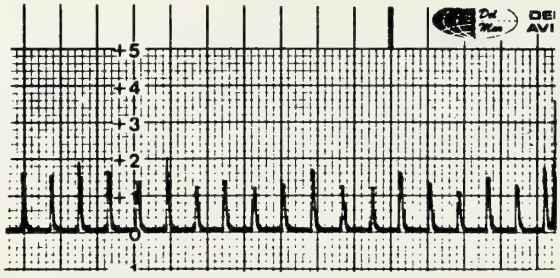
	Supra Orbital	Carotid	Tibial	Total Cases
Left CVS	3	3	2	4
Right CVA	2	3	2	6
	50%	60%	40%	100%

The wave amplitudes of the right and left supraorbital, carotid and tibial pulses in the ten patients with a cerebrovascular accident were compared. The highest percent impairment in descending order were the carotid, then the supraorbital and then tibial vessels.

Figure 3A
Case #12, Rt. Hemiparesis

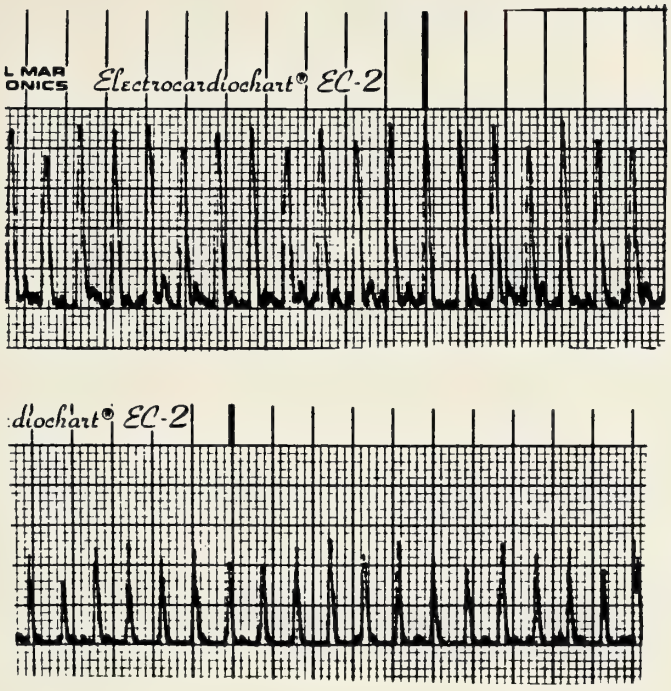


L. P.T.
amp. 1.8cm
rate 76bpm



R. P.T.
amp. 1.0 cm
rate 76 bpm

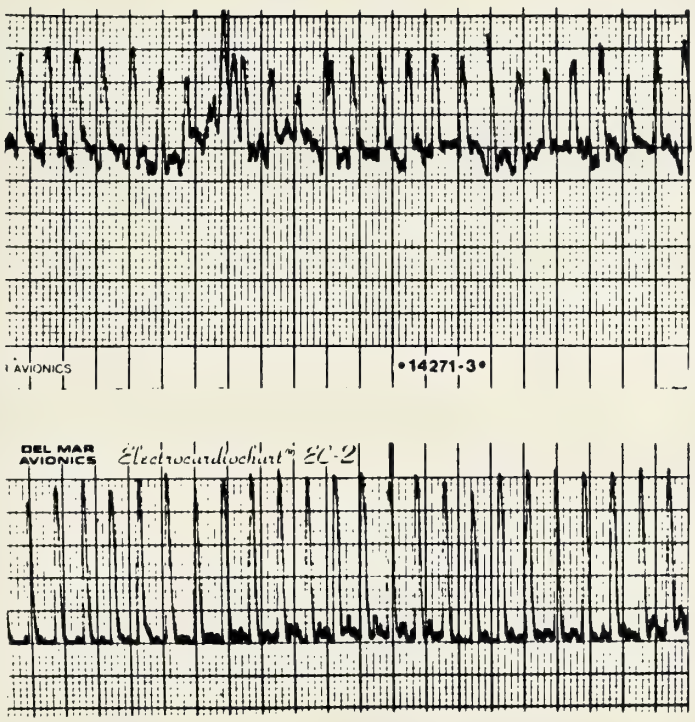
Figure 3B
Case #19, Dxrt, Hemiplegia, Peripheral Neuropathy



L. P.T.
amp. 2.5cm
rate 72 bpm

R. P.T.
amp. 1.4cm
rate 76bpm

Figure 3C
Case #20, 53 Yr Old, Left Hemiplegia



L. P.T.
amp. 1.5 cm
rate 72 bpm

R. P.T.
amp. 2.6 cm
rate 72bpm

Figure 3
Post tibial artery Doppler tracings in hemiplegic patients

Table 6
Confirmed Episodes of Heart Disease (12 Cases)

	Lt. Supra Orbital	Rt. Supra Orbital	Left Carotid	Right Carotid	Left Tibial	Right Tibial	
1)	.8	.7	2.6	2.2	1.8	—	
2)	—	—	2.6	1.8	1.0	.6	
3)	.4	.9	2.6	2.7	1.3	.9	
4)	—	—	2.8	2.0	1.4	1.6	
5)	.8	1.0	2.0	2.6	—	1.0	
6)	.6	.7	1.7	2.3	2.1	2.0	
7)	1.0	1.0	1.7	2.3	.7	—	
8)	.2	.8	2.0	2.3	2.0	2.5	
9)	.9	.5	2.2	3.0	1.9	2.0	
10)	.9	.8	2.6	2.6	1.0	1.0	
11)	.1	.2	2.2	2.0	.6	.4	
12)	.8	1.2	1.7	2.2	2.5	1.4	
	.53	.75	2.4	2.3	1.6	1.7	Mean
	.25	.27	.34	.41	.49	.79	Standard Deviation
	.28	.48	2.1	1.9	1.1	.91	Lower Range
	2	1	3	1	3	3	Case With Values below lower range

The wave amplitudes in the six blood vessels were computed in the 12 patients who exhibited EKG abnormalities. Six of these showed the tibial vessel wave amplitude below the standard deviation deducted from the mean.

Table 7
Nine Patients Without Confirmed Heart Disease

	Lt. Supra Orbital	Rt. Supra Orbital	Left Carotid	Right Carotid	Left Tibial	Right Tibial	
1)	.2	.4	2.1	2.0	1.3	1.6	
2)	.5	.5	2.7	2.7	1.2	—	
3)	1.0	1.0	1.7	1.9	—	.6	
4)	.5	.7	2.5	2.5	—	3.0	
5)	.6	1.3	2.6	2.8	2.7	1.9	
6)	—	.5	2.8	2.7	1.8	1.0	
7)	.6	.9	2.3	2.6	1.0	1.5	
8)	.5	.5	2.5	1.5	1.5	2.6	
9)	1.6	.2	2.7	1.7	1.0	.7	
	.61	.67	2.43	2.266	1.5	1.6	Mean
	.57	.48	.49	.696	.7	1.1	Stand. Deviation
	.04	.19	1.94	1.57	.8	.5	Lower Limit
	1	—	1	1	—	—	Cases Below Lower Limit

The 12 patients with confirmed heart disease on EKG showed 13 instances of wave amplitudes below the lower limits of the standard deviation. This occurred only in three instances in patients without confirmed heart disease.

monitoring in tests for intermittent claudication.[13] The larger the number of diffuse arteriosclerotic phenomena, the higher the risk of cerebrovascular accidents.[14] Ten of fifteen hemiplegic patients required amputations of the paralyzed extremities.[15]

The literature and our small study suggest that arteriosclerotic vascular disease may be manifest by localized symptomatologies, but the pathologic process is systemic and may involve, variably, the entire vascular tree. This would thus require a more comprehensive evaluation and treatment program.

The data on CVA cases show that the hemiplegic extremity is particularly vulnerable to pressure necrosis. The impaired blood flow, possible stasis, the sympathetic tone or the relative anoxia could predispose this hemiplegic extremity to skin breakdowns. The decreased tibial flow in patients with heart disease may also act as a natural deterrent to excessive ambulation. Both of these groups may thus have a greater incidence for venous

Table 8
Diabetes and Associated Diseases

No. of Diabetic Cases	CVA	MI or ASHD	Peripheral Vascular Disease
5	4	4	2

There were eleven patients with a history of hypertension and five cases with known diabetes. The wave amplitudes appeared equal for the diabetic and the non-diabetic patients, the hypertensive and non-hypertensive cases. Three diabetic patients had two of the above clinical diagnoses, one had all three and one case had only one of the above clinical entities. This would indicate multiple clinical involvements in diabetic patients.

thromboses. The multiplicity of vascular lesions increases the risk for cerebrovascular accidents. The data further suggest that diabetic patients tend to develop associated vascular lesions especially in the cerebral and coronary vessels and slightly less in the posterior tibial vessels. Any symptomatic therapeutic program must include alleviation of some of the etiologic factors to preclude the rapid onset of associated vascular processes, and prophylactic measures to prevent complications. The role of the autonomic nervous system in vascular lesions also warrants further evaluation.

Summary

The vascular status of 21 hospitalized patients was evaluated by the Doppler flow meter and EKG. A high incidence of multiple vascular impairments was noted in various structures, suggesting that symptomatologies of localized vascular lesions warrant a comprehensive evaluation and therapeutic approach toward the entire vascular tree. The etiologic factors precipitating a myocardial infarction, a cerebrovascular accident or complication of peripheral vascular disease may similarly involve the blood vessels to any other organ. Symptoms of localized vascular degenerative disease warrant prophylactic and therapeutic regimen of the entire vascular tree.

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Associated with Infectious Mononucleosis

Acute Inflammatory Polyneuropathy and Brachial Plexopathy

By Karen Scardigli, D.O. And José Biller, M.D./Cherry Hill, New Jersey And Iowa City, Iowa

Nervous system involvement as a complication of infectious mononucleosis has been well recognized. The first report of such association was by Johansen[1] in 1931 and by Epstein and Dameshek[2] later in the same year. The incidence of neurological involvement varies from 0.37%[3] to 26.5%.[4] This report describes a 33 year old woman with atypical presentation of acute inflammatory polyradiculoneuropathy and a 25 year old man with a brachial plexopathy in association with infectious mononucleosis.

The neurological manifestations of infectious mononucleosis are reviewed and the treatment and prognosis of acute inflammatory polyradiculoneuropathy are discussed.

The first case was a 33 year old woman admitted to her local hospital with complaints of headaches, diplopia, dysphagia, and paresthesias of both upper extremities of one day's duration. A week before admission she had experienced a sore throat, fever and myalgia.

General examination was normal. On neurologic examination abduction weakness of the left eye was noted, and the patient complained of diplopia on left lateral and upward gaze. Facial diplegia was present bilaterally.She had difficulty with tongue protrusion that deviated to the right. Gag reflex was diminished. Mild weakness of both upper extremities was noted and sensory examination was normal. Muscle stretch reflexes were absent bilaterally. Plantar responses were equivocal. Remainder of the neurologic examination was normal.

Laboratory evaluation on admission was unremarkable with the exception of an elevated uric acid at 7.1mg/dl. Heterophil test was doubtful. Lumbar puncture revealed clear CSF under normal pressure. Glucose was 75mg/dl and protein was mildly elevated at 59 mg/dl. Dexamethasone therapy was initiated. Three days after admission, bilateral ptosis, dysplagia and dysarthria developed. Repeat CBC revealed a WBC count of 10,200/cumm with 72% polymorphonuclear leukocytes, 1% monocytes, and 4% atypical lymphocytes. SGOT level was 76 IU/L (normal, 0-40 IU/L). Epstein-Barr virus titer was 1:640 (normal 1:20).

Three weeks after first admission, the patient was transferred to our hospital for further evaluation. General physical examination was unremarkable. Speech was dysarthric with impairment of labial sounds and palatal consonants. Marked weakness of neck flexors and moderate weakness of neck extensors were noted. Bilateral ptosis, weakness of eye abduction, left more than right, and bilateral weakness of eye adduction were evident. She could neither completely elevate both eyes when abducted nor depress them when adducted. Corneal reflexes were absent bilaterally. Facial diplegia was evident and masticatory muscles were moderately weak. Poor palatal movements were present; gag reflex was preserved. There was moderate weakness of both sternocleidomastoids and mild weakness of the trapezii. The tongue was atrophic, and fibrillations were noted on the left half. (Figure 1). Muscle strength was moderately diminished throughout and was most evident proximally. Sensory and cerebellar testing were essentially normal. Muscle stretch

reflexes were absent throughout. Plantar responses were flexor bilaterally. No improvement was noted following an edrophonium test.

Heterophil test was positive. Hepatitis B surface antigen (HBSAg) was negative. Epstein-Barr virus antibody titer was 1:160. Lumbar puncture revealed clear CSF under normal opening pressure; 8 WBC's were present (68% lymphs, 17% mons). Glucose was normal and protein elevated at 177mg/dl. CSF Epstein-Barr antibody titer was not elevated.



Figure 1
Bilateral ptosis, facial diplegia, and asymmetric tongue atrophy with scattered fibrillations.

Nerve conduction studies of the extremities revealed prolonged distal motor latencies in both median nerves consistent with bilateral carpal tunnel syndromes. Facial nerve latencies and blink reflexes could not be obtained. No denervation potentials were seen on EMG. However, interference patterns were diffusely decreased. A normal response to repetitive stimulation of the right median nerve was obtained.

Dexamethasone was tapered and six plasmapheresis exchanges were performed over ten days. The patient's clinical condition markedly improved within three weeks of admission to our facility, and she was discharged.



Figure 2
Recovery of tongue atrophy and fibrillations

Eight months following onset of her neurologic illness she had full recovery of ocular motility, facial strength and tongue atrophy (Figure 2, 3), but mild paresthesias of both hands and generalized areflexia remained. Nerve stimulation studies had been repeated and results were compatible with bilateral carpal tunnel syndromes. Facial nerve latencies were abnormal but markedly improved since the previous study. Subsequently, she underwent staged release of her median entrapment neuropathies with marked relief of her hand paresthesias.

Case 2

A 25 year old man was evaluated by his local physician for complaints of malaise, low-grade fever and sore throat of two weeks' duration. His throat was erythematous and tonsillar enlargement with exudates was noted. Anterior cervical lymphadenopathy was present. Heterophil test was positive. His symptoms resolved over the ensuing weeks. A month after the initial visit, he noticed pain, weakness and atrophy of the right shoulder girdle musculature without paresthesias. Muscle wasting progressed over the next two months. Three months later, he noted some improvement in his strength and increasing muscle bulk.

The patient was referred to our facility for further evaluation. General physical examination was unremarkable. Neurologic examination revealed mild atrophy of the rhomboid, supraspinatus, infraspinatus, deltoid, trapezius and serratus anterior muscles on the right. Winging of the right scapula was evident with outstretched arms (Figs. 4, 5). Direct muscle testing revealed normal strength, except for 4/5 weakness of the right deltoid and supra and infraspinatus. Sensory examination was normal to all modalities. Muscle stretch reflexes were normoactive throughout and plantar responses were flexor bilaterally. Remainder of the neurological examination was unrevealing.

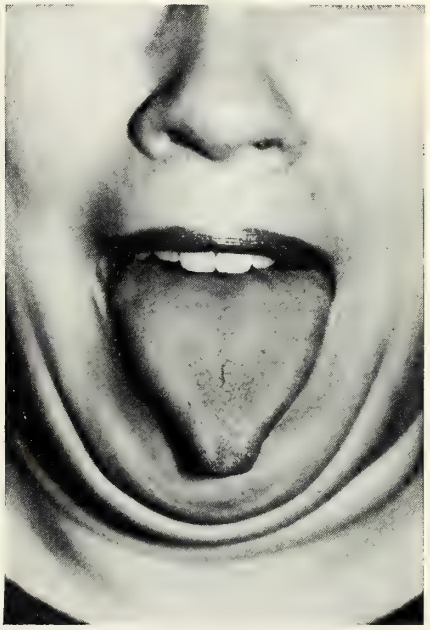


Figure 3
Recovery of ptosis and facial diplegia

General laboratory data was unremarkable. Heterophil test was equivocal; Epstein-Barr Antibody titer was 1:10 (N = 1:20). Nerve conduction studies of the upper

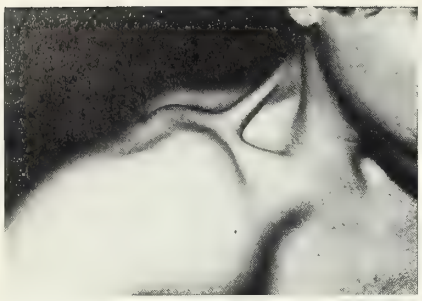


Figure 4
Atrophy of supra and infraspinatus, trapezius and deltoid.



Figure 5
Winging of the right scapula

extremities were normal; F-wave latencies and plexus latencies were normal. Electromyography demonstrated occasional denervation potentials in the right supraspinatus, deltoid, and serratus anterior. An increased incidence of polyphasic potential and decreased interference patterns were present in the right deltoid. Somatosensory evoked responses of the upper extremities were normal.

Discussion

Central nervous system manifestations associated with infectious mononucleosis include meningoencephalitis, encephalitis, focal and generalized seizures, and transverse myelitis.[5] P. Ruutu, *et al.*,[6] recently described a patient with pontocerebellitis which correlated with abnormal CCT findings. Involvement of the peripheral nervous system has been reported to take forms of Guillain-Barré[7] and Fisher's syndromes,[8] motor, sensory and mixed neuropathies,[7] mononeuritides, radiculopathies, and plexopathies.[7]

We believe that the young man in our second case had a right brachial plexopathy affecting the upper and middle trunk in association with infectious mononucleosis.

Our first case is of particular interest in that the patient had an atypical clinical presentation of Guillain-Barré (GBS) as well as laboratory evidence of infectious mononucleosis with minimal systemic manifestations present.

The Epstein-Barr Virus (EBV) and Cytomegalovirus (CMV) have been the two most common agents linked with the Guillain-Barré syndrome.[9] Grose, *et al.*,[10] have reviewed 24 cases of Guillain-Barré syndrome and found that seven were definitely associated with primary EBV infection. Only one of these patients had obvious clinical infectious mononucleosis and only a few demonstrated heterophil aglutinins. They noted that EBV must be considered in the diagnosis of various acute neurologic diseases affecting children and young adults, even in the absence of a heterophil antibody response or other signs of infectious mononucleosis.

The cause of the majority of deaths in GBS are respiratory failure and related complications, autonomic disturbances and pulmonary embolism. The mortality rate varies from 2.4% to 5.6%.[11] The value of steroids in the GBS has been a controversial topic. A large randomized British trial of prednisolone led to the conclusion that steroids have little effect on acute inflammatory polyneuropathy, and that if they do have an effect, it is detrimental rather than beneficial.[12] We elected to treat our patient with plasmapheresis due to her severe disability and poor response to steroids. A favorable outcome was obtained, although it is difficult to determine whether her recovery was spontaneous or secondary to plasmapheresis. A number of patients with acute inflammatory polyneuropathy have been treated with plasmapheresis, and in about half, treatment has appeared beneficial.[11]

Our patient exhibited marked recovery within six months of onset of her neurologic illness. With moderate intensive care the illness is usually not fatal and eventual complete recovery is the rule rather than the exception. In a series of 123 patients reported by Loffel, *et al.*,[13] three died and 90 were available for long-term follow-up. Of these, 57% recovered completely and only six were significantly handicapped.

Summary

We have described two patients with peripheral nervous system involvement secondary to infectious mononucleosis. Both patients exhibited marked recovery; a favorable outcome can be expected in most cases.

Acknowledgement

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SPECIAL ARTICLE

Impartial Medical Examiners Sought

For a number of years, ISMS has worked with the Illinois Industrial Commission and the Administrative Office of the Circuit Courts to provide the names of physicians to serve as impartial medical evaluators for disputed cases before those state bodies. ISMS is now in the process of updating this listing and invites member participation.

The procedure for impartial medical examination is essentially the same for both the circuit courts and the industrial commission. When a case requiring an impartial evaluation is identified, ISMS is contacted. The Society is asked to provide the name of a physician of a certain specialty, in a particular part of the state, to examine a patient. Physicians are listed by specialty and geographic area. A name at the top of the list of interested physicians is selected and an appointment is scheduled for the patient. The requesting agency is contacted and that body notifies the patient and asks him or her to see the physician. Following the examination, the physician is to submit his bill and a report to the requesting agency.

In a small number of cases, the physician may be asked to give a deposition of his examination, which is usually held in his office but may be held before a court or the industrial commission.

The physician is then placed on the bottom of the list of specialists in his or her region, and the next name on the list is used for subsequent requests for that area. Currently, referrals are infrequent and it is expected that no physician will be overburdened with requests.

Newly interested physicians and those currently serving as impartial examiners are asked to complete a questionnaire available from ISMS. Committees of the medical society will review each completed questionnaire. Physicians who meet the qualifications of the committees will be contacted and provided further information about the process.

Qualifications for impartial medical examiners include the following: meeting the requirements of medical society membership and obtaining approval, as appropriate, for participation by a county and/or specialty society; board certification or eligibility; and an impartial approach to workers compensation and court cases.

Interested physicians are asked to contact the ISMS Division of Medical Services, Twenty North Michigan Avenue, Suite 700, Chicago IL 60602; (312-782-1654). ◀

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Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

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United We Stand Divided We Fall

By Suzanne Meirink, President/ISMSA

Spouse membership in Auxiliary today is as important as paying your malpractice premimums. We are a special group—the spouses of physicians. There is no other profession that cares and heals as the physicians do—and we belong together.

The Auxiliary is a public relations entity for Illinois medicine. We can do more for the image of medicine than anyone or anything else. Today, when the medical profession is unfairly criticized by the media, the law profession or those patients who expect only perfect results, we need to bind together. We need each other as never before, and we need to counter the negativism against medicine. We are the ones who can do this because we are the ones who care the most about the future of medicine in Illinois and in the USA.

We are making many significant contributions to our state in the name of the medical profession. We are forming coalitions with other agencies and groups to show our support and interest in health care. We are networking with agencies, too.

The Auxiliary spends thousands of hours each year to educate our communities about wellness and good health, but without the support of more prospective members we cannot make the impact we need. ISMS has 16,000 physicians and less than 2,600 Auxilians.

Membership is our challenge this year. We need the support of all physician spouses. We need to show unity in our own ranks. Even if your spouse can't give the time to participate in an organized Auxiliary—she/he can still support the Auxiliary with membership. You can still show that you believe in medicine in Illinois.

Illinois is a state of which to be proud. We are a national leader in this nation in medical society programs and projects. We have some of the most dedicated physicians and Auxilians in the nation. Won't you show your loyalty to the Auxiliary and see that your spouse becomes part of us? ◀

A Personal Experience

The Medical Disciplinary Board

By Helen R. Beiser, M.D./Chicago

The procedures of the Illinois Medical Disciplinary Board are described, from the initiation of a complaint, through the hearing process, to the monitoring of recommendations made by the Board. The major types of complaints are described, as well as the types of physicians likely to get into trouble. There are a number of possibilities for research and prevention.

(Editor's note: A related story appears on page 49)

Illinois physicians might find more knowledge about the Illinois Medical Disciplinary Board and how it functions to be of interest and value. As I have recently left the Board, this is not an official statement, but a personal observation.

My appointment by the Governor started July 1, 1979, and I served four and a half years, which is beyond the usual four year term. Although one is expected to serve until replaced, it was necessary for me to resign in order to add my new duties as president of the American Academy of Child Psychiatry to an active private practice of psychoanalysis and related professional activities.

You might ask what a child psychiatrist is doing on a medical disciplinary board. Actually, my long years of experience advising parents on the discipline of their children, especially delinquent adolescents, was good background. I also served on the student discipline committee of the University of Illinois College of Medicine some years ago, on the peer review committee of the Illinois Psychiatric Society, and was a site visitor for continuing medical education for both the American Medical Association and the Illinois State Medical Society. Although I actually think that I may have been appointed to represent women, I think one should also have some relevant credentials.

The law requires that the Board consist of an osteopath, a chiropractor, five MDs and two nonvoting public members. Members tend to reflect the various geographic areas of the state, various minority groups, and various fields of the practice of medicine. All shared a dedication to the quality practice of the medical arts, and a desire to help its practitioners toward that goal.

The Setting

It must be understood first of all that the Board is not autonomous, but works within the State Department of Registration and Education. The Department regulates over 50 different occupations, from licensing examinations to various forms of supervision of remarkably disparate groups. There were times when boxers and their managers blocked the way to our meeting rooms, when we were evicted for a meeting of the Real Estate Board, and when I overheard a group of beauty operators on their way to their licensing examination discuss the definition of the vagina in the elevator. This initial impression of confusion did not diminish much, especially when the Department moved to smaller temporary quarters a couple of years ago while waiting for the completion of the new glass State of Illinois Building. We did not know whether a hearing would take place in the corner of a huge examination room or in a small office crowded with ancient furniture. At least in this department, the State does not waste its money on amenities.

Of greater concern was the conflict between the various groups which must work together in order

for the disciplinary process to operate smoothly. The cooperation of the clerical staff, investigators, medical coordinator, legal staff, and the director of the Department with the Board is essential. Slowdowns can take place at any level, and frequently did when I first started. The present administration of the Department has worked very hard to resolve problems of insufficient or inadequate personnel, differences in attitude or philosophy, and is vigilant to take care of new problems which inevitably arise. This has put to rest the wishes of many Board members to separate it from the Department, but changes in the administration may again arouse a desire for autonomy.

Although tension between medical and legal personnel has eased considerably, perfect harmony is probably not possible because of basic differences in philosophy and modes of operation. I slowly became accustomed to legal processes and thinking, but could never quite share the positive feelings which the mention of "due process" seems to arouse in lawyers. I was once told that my appreciation would increase if *I* were under investigation. To me, it seemed to result in multiple continuances, complicated motions, and opaque legal language which resulted in lengthening the process without reassuring me that justice was necessarily being served. However, I *did* see the benefits of having a good lawyer, and would not recommend that a doctor take on his own defense. As a hearing officer, I found that I preferred quiet spoken lawyers who stuck to the facts rather than the shouters and accusers. Aside from the problems of understanding legal language and process in conducting a hearing, the greatest difficulty I encountered was in receiving information in an unaccustomed way, although in the relatively informal hearing, Board members could ask questions. Delays are also encountered because the Board meets only on the first and third Wednesdays of each month. It is very difficult to schedule cases efficiently as it is hard to predict which cases will be very short, and which will be very long and complicated. I once sat on the same case for over a year.

Procedures

It might be useful to review the process by which the Board works, although this is always subject to some change. Complaints are received in writing or telephone by clerical staff in the Department, and turned over to a department of investigation. Investigation may also be initiated on the basis of stories in the media or a computer check of unusual prescribers of controlled substances. Another source is the reports of disciplinary actions from other states, if the physician also holds an Illinois license. Recently, procedures have been worked out to handle mandatory reports of malpractice settlements and disciplinary actions by hospitals, medical societies, and courts. After a preliminary determination of available facts, and complainant willingness to cooperate, the case is reviewed by the medical coordinator, a physician employed by the Department but responsible to the Board. He works with the investigators to determine what information is needed to decide whether the physician has indeed acted in a way contrary to the Medical Practice Act, and presents his opinion to the complaint committee. This screening committee includes two members of the Board, who then will not be assigned to the formal hearing for any case they have screened. The complaint committee may close the case if there is no evidence of illegal practice, refer it back for further investigation, hold an informal conference with the physician to get further information, or refer it to the legal department for prosecution. The legal department reviews the material to see if there is sufficient evidence to warrant prosecution, and may then prepare its case, or return it to the complaint committee if the evidence is insufficient. Actions of the complaint committee are reviewed by the full Board.

If the physician admits the charge, either at the time of an informal conference or during the legal preparation of the case, a consent order may be drawn up, saving the time and expense of a formal hearing. The content of a consent order may be quite similar to the recommendations made after a hearing, and will be discussed under that topic. If the physician (legally designated the respondent) does *not* admit the charge, and the legal department feels it has sufficient evidence to support the charge, a formal hearing is scheduled. I will not further describe formal hearings, except to say that the chairperson of the Board appoints a chief hearing officer, and as many other members of the Board as are not otherwise occupied are expected to attend. After the completion of the hearing, the legal transcript is reviewed by all, or at least a majority of the Board, and recommendations are worked out in an executive session of the full Board. These are included in a legal document which must also contain findings of fact and conclusions of law, and submitted to the director of the Department of Registration and Education for his approval. If he disagrees, he may request the Board to reconsider its decision and/or recommendations. Recommendations cannot be legally carried out until the director signs the order. It has been of great help when the Board has had its own legal counsel to help write rules of procedure, advise on the issues that arise in this complicated process, and write up the legal document including the recommendations for the director, especially in those situations where there have been sharp disagreements between the prosecuting attorney and the Board.

Types of Complaints

Probably the largest number of complaints that come to the Board's attention relate to non-therapeutic prescribing of controlled substances. The reasons range all the way from medical incompetence to clear sale to addicts. Another group of complaints involve defrauding third party payers, like Medicaid or insurance companies. Another group, which are usually quite easy to judge, are reports of disciplinary action in another state. The Illinois Board does not retry the case, but merely decides what limits need be placed on such a physician if he wishes to practice in Illinois. Much harder to judge are cases of unpro-

fessional behavior, including sexual activity with patients, and incompetence resulting in death or harm to patients. A single error, even with serious results, is not general incompetence.

A new problem has arisen with the recent law requiring mandatory reporting of disciplinary action of hospitals and medical societies, and malpractice cases where a judgment has been made against the doctor. It is necessary to separate out personality difficulties with hospital personnel from behavior detrimental to patients, and meritorious malpractice cases from non-meritorious ones. Finally the Board does receive complaints about fees, but rarely acts on these, as local medical societies are believed to be in a better position to judge their reasonableness. The Medical Practice Act, which I recommend reading (I must admit that I did not until appointed to the Board), does not require perfection, but reasonable competence as judged by practice within a given community. A copy of the Act may be obtained by writing to the Department of Registration and Education.

Types of Respondents

What sort of physicians get into trouble? There is a tendency to believe that anyone who gets through medical school and is licensed must be a good person who would never do anything to the detriment of a patient, at least not deliberately. Unfortunately, there *are* a few physicians, whom I would technically diagnose as sociopaths, but would just be called crooks by the lay public. They are clearly out for personal gain, either of money or power, and are involved in cases of fraud, sale of controlled substances, or using patients for sexual gratification. Some have been convicted of non-medically related felonies.

A somewhat larger group falls under the general category of the impaired physician. This includes not only the drug addict and alcoholic, but the mentally ill, the physically ill, and those with senile changes. The Board has worked with the Impaired Physicians Committee of the Illinois State Medical Society, not as a source of information for complaints, but to use them as a resource for helping those who have gotten into trouble. Of course, the impairment does not come to the attention of the Board unless it results in some incidents of poor medical practice, and it is to be hoped that the medical society committee may be able to prevent situations from going that far. I had the opportunity to attend the American Medical Association's Conference on the Impaired Physician, and learned about some nationwide efforts in this direction, as well as the experiences of other state regulatory bodies. Regulation can be much tighter and more personal in the smaller states.

The third group may be considered ignorant or misguided. Some physicians become the dupes of addicts, and some go along with their requests believing that they are helping them. In general, these are physicians who will do what the patient asks rather than what is medically indicated. This may also result in succumbing to sexual seduction as well as non-therapeutic prescribing. Others have a personal code of ethics which they put above the law. A Robin Hood philosophy sometimes justifies fraud. The government or other impersonal organization can be cheated in order to provide services for the poor. What is perceived as the patient's welfare is put above the law, and this is considered a virtue.

Of course, there may be combinations of the above categories. It may be hard to differentiate a Robin Hood from a crook. The ignorant may be alcoholic, and there may be other combinations. The point I wish to make is that it is as necessary to understand the person who is under consideration as well as the specific illegal behavior in order to devise a reasonable remedy.

Recommendations

This leads into the subject of the recommendations. The Board has had a philosophy of rehabilitation, if at all possible, rather than punishment. Where clear criminal behavior has been committed by a sociopathic personality, revocation of the license is usually indicated, although the respondent may be given one opportunity on probation. The Robin Hood personality is usually not as serious, and enough of a penalty, usually in the form of a meaningfully long suspension, is utilized to get across the message of the need to respect the law. If a felony has been committed, the criminal court has already imposed a penalty, but the Board decides if any restrictions on the license must also be imposed. Falsification of income tax returns may not affect medical practice, but assault with a deadly weapon might. In the case of senile changes or serious physical illness, the physician may be persuaded to retire from practice, and would have the license revoked only if he or she refused to accept this recommendation. In the case of mental illness and/or substance abuse, psychiatric treatment may be required. If there has been personal or non-therapeutic prescribing of controlled substances, this license may be revoked, leaving the physician the opportunity to carry on whatever practice would not require controlled substances.

For the ignorant, education is required. It soon became clear that the ordinary continuing medical education programs were inadequate for this purpose. The specific gaps in information that a given individual needed filled were just not offered. The Board is slowly developing a network of contacts with medical schools, hospitals, and individual experts to teach well-meaning but ignorant physicians in trouble what they need to know. For example, drug addicts have been using weight reduction drugs for other purposes. This requires training in methods of spotting and handling of addicts, as well as instruction in the limitations of drugs in weight reduction. It is best that these educational programs be termed remedial medical education.

Essential to any disciplinary process is the ability to see that recommendations are carried out. The first requirement is to make recommendations that *can* be monitored. For example, quarterly letters from employers when practice has been restricted can be required, as well as spot urine checks on substance abusers. Psychiatrists can report

that the physician has been attending, but one cannot expect that any treating physician can objectively judge whether a patient is ready to resume practice. Trained investigators can determine whether the physician is indeed not practicing, if the license has been suspended or revoked. A check with area pharmacists as well as the computerized triplicate prescription forms can monitor prescribing habits and restrictions. If the physician is allowed to continue in private practice, it is not possible to check on sexual activity with patients, or limiting the practice in a prescribed way. Monitoring has improved greatly, but it takes imagination and the cooperation of the Board with trained and experienced investigators to develop it to an optimal degree. Early in my term, restrictions were placed in the recommendations, and the physician placed on probation for a year or two. Sometimes the probationary period was up before any attempt to check compliance with the recommendations had been made.

Other Areas of Interest

An area of interest to me, although it would require extra funding, is the possibility for research. It may be that the professional societies, who always have observers at Board meetings and cooperate with it in a variety of ways, might want to consider this. Other states have studied the types of complaints, and changes with changes in the law, or in the institution of disciplinary processes. I have wondered if my impression that foreign born and/or trained physicians have more difficulties than American born and/or trained is valid, and the black Board member has wondered the same about minority physicians. I have learned that women are not immune from trouble, but do not know the proportion. It would be of great interest to study the effectiveness of various interventions, and of the closeness of monitoring. Eventually, important information will be available on the percentage of malpractice settlements actually warranting action relating to a physician's license.

Another area for consideration is prevention. The medical schools might look into how substance abuse gets started. Is it a result of various pressures which then continue into medical practice? I have been struck by the thought that the ideal of medical activity inculcated into medical students comes perilously close to a mild manic phase of bipolar disease, formerly known as manic-depressive psychosis. Manic disease and alcoholism are often combined. Schools might also be more aware of unethical behavior during the educational process. When I was on the student discipline committee, we had a case of forgery of a controlled substance prescription. The student was dismissed shortly before graduation, a terrible shock to the student body, but which saved him from federal prosecution. Unfortunately, although I have done many screening interviews, I have never been able to diagnose with any surety a sociopathic individual. When such a behavior pattern becomes clear, however, it is important not to give them a diploma, certificate of training, or license. At the very least, it might be considered that the graduating medical student be made aware of the Medical Practice Act and a copy could be sent with at least the *initial* license to practice medicine.

I became aware of many complexities in the process of regulating the professions. A disciplinary board needs to know something about the function of the examining board, as it may be better to be tough *before* licensing. The medical board began to cooperate with the pharmacy and nursing boards on some cases. In all regulation there is the conflict between civil rights and protection. In gathering evidence, the confidentiality of records can interfere with properly studying a physician's practice. But some of the stickiest problems concerned unlicensed groups, such as napraths. Here a license cannot be removed, but should this group be licensed? If not, should they be prosecuted for practicing medicine without a license? This is up to the States Attorney, not the Department of Registration and Education.

Conclusion

All in all, this experience has been very educational for me, and I have especially appreciated working closely with a group of dedicated professionals who wish to improve the practice of their members for the benefit of patients, and who, in spite of great disparity in backgrounds and areas of expertise, were able to work together without a major disagreement. I hope this description of the process and personnel helps the membership understand the need for a large licensing fee, as this gives the Board a certain degree of autonomy within the Department of Registration and Education. Under the Open Meetings Act, anyone may observe the business meetings as well as the formal hearings of the Board, on the first and third Wednesdays of the month. As an occasional meeting is held in Springfield, it would be advisable to call ahead to check on time and place. Meetings are held in the offices of the Department of Registration and Education, in the new State of Illinois building (100 W. Randolph St., Ninth Floor, Chicago IL 60601). The telephone number is 312-917-4486. ◂

Helen R. Beiser, M.D., Chicago, is a board certified psychiatrist with subspecialty certification in child psychiatry. A clinical professor emerita in psychiatry, University of Illinois College of Medicine, Dr. Beiser served as a member of the Illinois Medical Disciplinary Board, 1979-1984. She is a faculty member at the Chicago Institute for Psychoanalysis and has taught at the Institute for Juvenile Research. Dr. Beiser is both president of the American Academy of Child Psychiatry and a former president of the Chicago Council of Child Psychiatry. A former councilor and peer review committee member of the Illinois Psychiatric Society, she has also served on the peer review panel for the Chicago Psychoanalytic Society.

SPECIAL ARTICLE

To the Medical Practice Act

Mandatory Reporting Amendments

Mandatory reporting amendments to the Illinois Medical Practice Act came into effect January 1, 1983. In recent correspondence, Charles K. Wells, M.D., Medical Disciplinary Board secretary, provides brief highlights of the amendments. He concludes with an encouragement that physicians who are subjects of mandatory reports seek copies of the original reports and promptly respond to them.

Public Act 82-1036 changed the Medical Practice Act, which is the law that provides for licensure and discipline of medical doctors, osteopaths, and chiropractors; this change became effective January 1, 1983.

The new law requires certain reports concerning the practice of medical doctors, osteopaths, and chiropractors to be made to the Medical Disciplinary Board by (1) licensed health facilities, (2) professional associations, (3) malpractice insurers, (4) states attorneys and (5) public agencies.

Licensed Health Facilities

When the governing body of a licensed health facility has made a "final determination" to terminate or restrict a physician's clinical privileges due to the fact that a physician has committed an act constituting "unprofessional conduct," that body must report such act to the Medical Disciplinary Board. A licensed health facility is mandated also to report to the Medical Disciplinary Board if it finds that a physician is "impaired," either mentally or physically, and the facility has placed that physician under a written supervision.

Professional Organizations

Professional organizations are required to report to the Medical Disciplinary Board after a "final determination" that a member of the group has committed "unprofessional conduct."

Professional Liability Insurers

Professional liability insurers are required to report to the Medical Disciplinary Board settlement of any claim when the settlement or final judgment was in favor of the plaintiff.

Reporting by States Attorneys

The States Attorney of each county is required to report to the Medical Disciplinary Board all instances in which a physician is convicted or found guilty of committing a felony.

Reporting of Public Agencies

An agency, department, or commission affiliated with the State of Illinois is required to report to the Medical Disciplinary Board any instances arising in connection with operations of the agency where it finds a physician has committed an act which may (1) be in violation of the Medical Practice Act (2) constitute unprofessional conduct directly related to patient care or (3) indicate that the physician is mentally or physically disabled in such a manner as to endanger patients.

After the report is received by the Medical Disciplinary Board, the agency has 30 days to notify, by certified mail, the physician who is the subject of the report. The physician is to be notified of the right to examine the report's contents and to submit a written statement clarifying, adding to or proposing amendments to the report. The physician should write to the Medical Disciplinary Board and request a copy of the report since a report will not automatically be sent out.

Following a receipt of the notification, the physician has 30 days to submit, if desired, a response to the Medical Disciplinary Board.

Physicians! *Please reply to the mandatory reports* so that the Medical Disciplinary Board will have both sides of the question. This will help the Board in its deliberations. ◀

Charles K. Wells, M.D.
Mount Vernon
Secretary
Medical Disciplinary Board

Editor's Note The mandatory reporting amendments were summarized and analyzed in the February and March, 1984, issues of *IMJ*. That summary was based upon a booklet developed by ISMS, the Chicago Medical Society, the Illinois Hospital Association and the Chicago Hospital Council. Copies of the booklet are available from the Society offices, Twenty North Michigan Avenue, Suite 700, Chicago 60602; (312-782-1654).

DOCTOR'S NEWS

PHYSICIANS IN THE NEWS

Sadiq Mohyuddin, M.D., Godfrey, has been installed as president of the medical staff of St. Anthony Hospital, Alton. Dr. Mohyuddin, who was elected for a two-year term, is immediate past president of the Madison County Medical Society and an Illinois State Medical Inter-Insurance Exchange Network Representative. . . **Tien C. Cheng, M.D.,** was recently elected to the American College of Chest Physicians. Dr. Cheng also is a fellow of the American College of Cardiology, American College of Physicians, and the Council of Clinical Cardiology of the American Heart Association. . . The American College of Physicians has elected **Gershom K. Greening, M.D.,** Springfield, to fellowship. Dr. Greening, an internist, serves on the staffs of Memorial Hospital, St. John's Hospital, and Humana Hospital in Springfield. He is a graduate of the University of Illinois School of Medicine.

Patrick J. Scanlon, M.D., Maywood, has been elected the American College of Cardiology's Illinois governor. College Governors, who serve three-year terms, are responsible for reviewing all applications for membership to the College within their areas and for making recommendations to its Credentials Committee. Dr. Scanlon is professor of medicine and chief of the cardiology section at Loyola University Medical Center, Maywood. Carter Barclay Hospital, Chicago, has named **David G. Bawden, M.D.,** also of Chicago, its medical director. Prior to his appointment, Dr. Bawden served as supervisory psychiatrist at Michael Reese Hospital's Residency Program. He currently teaches and supervises in the clinical schools services program at the Institute for Psychoanalysis. **Peter McKinney, M.D.,** Chicago, has been elected secretary of the American Society for Aesthetic Plastic Surgery. Dr. McKinney is professor of clinical surgery at Northwestern University and maintains a private practice. **Richard A. Perritt, M.D.,** has been named as the first president-elect of the United States Section of the International College of Surgeons. Dr. Perritt has served as secretary and treasurer of the U.S. section as well as chairman of its board of trustees. He also has been chief of the Section of the Ophthalmology for the College's U.S. and international sections. Dr. Perritt recently was invested Knight of the Equestrian Order of The Holy Sepulchre of Jerusalem. The appointment was made by papal decree to honor Dr. Perritt for the contribution of his services in eye care to several Popes and Vatican prelates over the years.

DERMATOLOGISTS TO HOST CLINICAL MEETING

The annual meeting of the Illinois Dermatological Society will be held Saturday and Sunday, October 12-13, at the Westin Hotel in downtown Chicago. On Saturday afternoon, 2:00-5:00, Stephen I. Katz, M.D., chairman of the department of dermatology for the National Institutes of Health, will discuss dermatitis herpetiformis. On Sunday morning, 9:00-noon, Martin Mihm, M.D., head of the department of dermatology at Massachusetts General Hospital, will present comments on the value of dermatopathology in emergency cases and an update on malignant melanoma.

Illinois Dermatological Society President Silas Wallk, M.D., will coordinate the meeting. Dr. Wallk, an associate professor of dermatology at the University of Illinois College of Medicine, is a past president of the Chicago Dermatological Society and also the current president of the Great Lakes Dermatological Society. Board certified in dermatology and dermatopathology, he was the 1983 Chicago Dermatological Practitioner of the Year and serves as director of the Chicago skin cancer screening program.

Further information about the annual meeting may be obtained through the Illinois Dermatological Society offices at Twenty North Michigan Avenue, Suite 700, Chicago IL 60602 (312-263-7150). There is no charge for Illinois Dematological Society members; non-members are welcome to attend at a cost of $40. A dinner is scheduled for Saturday evening (cost to be determined.)

IDPA NOW RESPONSIBLE FOR DCFS PATIENTS

Effective July 1, 1985, the Illinois Department of Public Aid assumed responsibility for processing payment claims for medical services rendered to approximately 8,000 wards of the Department of Children and Family Services who currently carry "pink" cards. Under the new system, the pink card process will become obsolete and all DCFS wards will be issued a monthly Medical Eligibility Card by IDPA. Fee schedules, prior approval requirements and claim processing procedures applicable to the Medicaid Program will be used, according to Thomas J. Walsh, IDPA's Medical Programs Administrator.

A comparison of DCFS files with Medicaid records revealed that less than five percent of those currently reimbursed by DCFS are not enrolled in the Medicaid Program. Those physicians must now enroll to be paid for services rendered to the DCFS patients. Physicians wishing to enroll in the Medicaid Program should contact Donna Withrow at IDPA, (217) 782-0538.

CORRECTIONAL HEALTH CARE FOCUS OF CONFERENCE

The ninth annual National Conference on Correctional Health Care has been scheduled for Nov. 7-9 at the Chicago Marriott Hotel. The conference is a national forum for professionals working in corrections to explore new trends in correctional health care, to exchange ideas with colleagues, and to develop new strategies to meet old concerns. This year's conference is expected to draw more than 600 physicians, dentists, nurses, mental health workers, and correction and other professionals. The American Medical Association is a co-sponsor for continuing education credits.

New Officers Inducted

By Catherine M. Hill, CMA and Robin Bluestein, CMA-C/Palatine and Chicago

On April 27, 1985, Judith Miller, CMA-AC, installed the 1985-86 officers of the Illinois Society, American Association of Medical Assistants at the Marriott Hotel in Oak Brook, Illinois.

Ehlma Garcia, CMA, EMT-A, West Cook Chapter, was installed as president. Ms. Garcia has been a medical assistant for ten years and a member of the organization for nine years. Her primary goals are to increase membership, expand visibility of the Society and promote continuing education and certification.

Elected officers, who will be working with Ms. Garcia to fulfill these goals are:

- Anna Cannon, EMT-A, Chicago Chapter, immediate past president of the Illinois Society, AAMA.
- Mary Lu Ostrowski, CMA, President elect, McLean Chapter;
- Cheryl Hutchinson, CMA, first vice president, St. Clair Chapter;
- Lesa B. Hildebrand, CMA-C, second vice president, West Cook Chapter;
- Robin Bluestein, CMA-C, recording secretary, Northwest Cook Chapter;
- Jewel Nelson, membership secretary, Vermilion Chapter;
- Mary Frances Burton, treasurer, Chicago Chapter;
- Jean Fouts, LPN, speaker of the house, McLean Chapter; and
- A. Ruth Thompson, CMA, vice speaker of the house, St. Clair Chapter.

Appointed officers, who will also participate in achieving the above mentioned goals, are:

- Luella Mitchell, CMA, parliamentarian, Chicago Chapter;
- Marjorie Anderson, CMA-C, corresponding Secretary, West Cook Chapter;
- Elva Kowalski, chaplain, Peoria Chapter; and
- Julie Stoffregen, CMA, historian, Northwest Cook Chapter.

According to the American Association of Medical Assistants (AAMA), a medical assistant is a professional, multi-skilled person dedicated to assisting in all aspects of medical practice under the supervision of a physician. This practitioner assists with patient care management, executes administrative and clinical procedures, and often performs managerial and supervisory functions. Competence in the field also requires that a medical assistant communicate effectively, adhere to ethical and legal standards of professional practice, recognize and respond to emergencies and demonstrate professional characteristics.

Information regarding the Illinois Society and/or medical assisting can be obtained from Ehlma Garcia, CMA, EMT-A, president, Illinois Society, 6134 South Tripp, Chicago, Illinois 60629; Robin Bluestein, CMA-C, co-chairman, Public Relations Committee, 2247 West Estes, #2, Chicago, Illinois 60645 or Catherine M. Hill, CMA, co-chairman, Public Relations Committee, 900 South Plum Grove Road, Palatine, Illinois 60067. ◂

MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

(Continued from page 8)

A group of 49 women who reported repeated spontaneous abortions were treated with injections of their own lymphocytes or with lymphocytes from the impregnator. Seventeen of 22 women given paternal cells had successful pregnancies compared to 10 of 27 given their own cells. All cases had previously experienced between three and eight abortions with the current partner, were not Rh-negative, did not show presence of cytotoxic antibodies against paternal lymphocytes and were not pregnant at the time of the study. (Mowbray, J., *et al: The Lancet* 8435:1, 941-3, April 1985)

Quinidine was used intravenously in 14 patients with severe falciparum malarial infections. The initial dose of 15mg/kg body weight was followed by 7.5mg/kg every eight hours. Two of five cases with cerebral infestation died, but parasitemia was eliminated in 12 survivors. Blood pressure fell in two cases on this regimen. ECG changes were common but no dysrhythmias were noted. Relapses occured in two patients on the 25th and 28th days, respectively. (Phillips, R., *et al: N Engl J Med* 312:20,1273-8, May 1985)

The authors followed 1221 residents of Rochester, 30 years of age or older, who sustained a myocardial infarction without preexisting heart failure or valvular disease. Transmural infarcts were diagnosed in 784 cases, exhibited a 30 day mortality rate of 18% and showed greater preponderance for congestive heart failure. Subendocardial infarction was diagnosed in 353 cases with a 30 day mortality rate of 9% and sequellae of anginal attacks. (Connolly, D. and Elveback, L.: *Mayo Clin Proc* 60:6,375-81, June 1985)

The Food and Drug Administration has approved the administration of indomethacin intravenously to premature infants weighing 500-1750gm with patent ductus arteriosus within 48 hours of birth. Indomethacin is a potent inhibitor of prostaglandin synthesis and anti-inflammatory agent. It may replace surgery for as many as 16,000 babies a year. Its use is contraindicated in babies with infections, bleeding, thrombocytopenia, coagulation defects, necrotizing enterocolitis and impaired renal function. (FDA Drug Bulletin, 15:1,4-5, April 1985)

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September, 1985-November, 1985

Current Clinical Neurology: A Comprehensive Review
September 9-13, 1985
Sexual Medicine
September 11-13, 1985
Specialty Review in Dermatology
September 16-20, 1985
Specialty Review in Endocrinology and Metabolism
September 30-October 4, 1985
Specialty Review in Medical Oncology
September 30-October 4, 1985
Specialty Review in Cardiovascular Disease
October 7-11, 1985
Advanced Peripheral Vascular Surgery
October 7-11, 1985
Anatomic Pathology: A Comprehensive Review and Update
October 12-16, 1985
Specialty Review in Gastroenterology
October 14-18, 1985
Clinical Pathology: A Comprehensive Review and Update
October 17-20, 1985
Specialty Review in General Surgery, Part I
October 21-November 1, 1985
Current Cardiology
October 28-31, 1985
Specialty Review in Obstetrics and Gynecology
October 28-November 2, 1985
Fiberoptic Esophagogastric Endoscopy
November 11-13, 1985
Advances in Internal Medicine
November 11-15, 1985
Flexible Fiberoptic Sigmoidoscopy
November 16, 1985

For further information, write:
The Cook County Graduate School of Medicine
707 S. Wood St., Chicago, IL 60612
Or call toll-free:
800-621-4651 (in Illinois, call 800-621-4649)

PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

BLOOMINGTON:
Internal Medicine—To join an active six member IM practice in mid-western university community. A sub-specialty in Rheumatology, Endocrinology, or Allergy is desirable, but not necessary. Contact: J. Buchanan, The Health Center, 702 N. East St., Bloomington 61701 (309-827-5051). (9)

BRADFORD:
Family physician wanted to take over 32 years of well established rural practice with office and house—reason retirement. 120 bed equipped hospital 20 minutes drive, 35 miles from major medical and educational center. Elementary and high school 2 blocks from home. Contact (309) 897-8181. (6)

DES MOINES, IOWA:
Obstetrician and Gynecological Physician—Planned Parenthood of Mid-Iowa. A reproductive health care agency serving 17,000 patients. New medical center, exciting progressive agency, a leader in the state. Des Moines is a progressive city with a totally revitalized downtown area. Contact Dan Topp, Executive Director, P.O. Box 4557, Des Moines, Iowa 50306, (515) 280-7000.

FAIRFIELD:
Lucrative family practice Southern Illinois available, including office building, all equipment (x-ray, electrocardiogram, diathermy, three Birthcher's, Lab). Can accomodate two to three physicians. More information can be obtained by calling (618) 842-2187. (6)

GLEN ELLYN:
Full or Part-Time Radiologist—Position in 60-physician, multispecialty, outpatient facility for radiologist. Facilities include flouroscopy, tomography, mammography, diagnostic ultrasound, plus general radiology. Salaried position with excellent fringes, excellent workload and hours in comparison with hospital setting, plus the ability to work with a quality leading group in a pleasant suburban environment. Send CV to: Glen Ellyn Clinic, 454 Pennsylvania Avenue, Glen Ellyn 60137.

KANE COUNTY:
Experienced occupational health physician needed to direct medical program in manufacturing plant in Southwest Suburbs. Call regional medical director (312)981-2195. (4)

ROCK ISLAND:
Internist group looking for a fourth physician to join growing area of Illinois Quad Cities. General internist and/or internist with sub-specialty willing to practice some general internal medicine. Offering financial guarantees and free rent for first year. Contact: Greg Romans, 2701 17th Street, Rock Island, IL 61201. (3)

SAYBROOK:
Family practitioner—Excellent opportunity in east central Illinois; large modern office available; rural setting near modern well equipped community hospital; community is within twenty minutes of major universities, tertiary care centers; metropolitan area with major shopping, recreational and cultural activities available; financial incentives possible. Contact William Stack (309) 475-3521. (3)

VANDALIA:
Specialists wanted. Family practice, internal medicine, pediatrics, general surgery, ENT, orthopedic surgery. One year guarantee with free office space. Needed for 92 bed acute, 134 bed LTC hospital in southern Illinois. Market covers 25,000+ people. Single office or clinic setting possible. Contact: Darrell Pile, Adm., Fayette Co. Hospital, Taylor Street, Vandalia, 62471 (618) 283-1231. (3)

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

AUGUST

Surgery

Specialty Review in General Surgery, Part II
For: General and specializing surgeons. Lecture, August 19-30, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $750. **Reg. Limit:** None. **Credit:** Category 1: 100 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649; outside Illinois: (800) 621-4651.

Fiberoptic Colonoscopy
For: Surgeons, Internists, Gastroenterologists. Lecture, August 21-23, Chicago. **Speaker:** Herand Abcarian, M.D. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $490. **Reg. Limit:** 20. **Credit:** Category 1: 15 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649; outside Illinois: (800) 621-4651.

Fiberoptic Esophagogastric Endoscopy
For: Surgeons, Internists and Gastroenterologists. Lecture, August 26-28, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $490. **Reg. Limit:** 15. **Credit:** Category 1: 16 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649; outside Illinois: (800) 621-4651.

Pediatrics

Specialty Review in Neonatology/Perinatology
For: Pediatricians and Obstetricians. Lecture, August 26-30, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $610. **Reg. Limit:** None. **Credit:** Category 1: 53 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649; outside Illinois: (800) 621-4651.

Medicine

Specialty Review in Internal Medicine, Certifying
For: Internists and Medical Subspecialists. Lecture, August 4-10, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $650. **Reg. Limit:** None. **Credit:** Category 1: 74 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649; outside Illinois: (800) 621-4651.

SEPTEMBER

Emergency Care

Advanced Trauma Life Support Provider Course
For: Physicians, Emergency Personnel, Nurses, Course, September 11-12, 8:00 A.M.-5:00 P.M., Springfield. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $350. **Reg. Limit:** 20. **Credit:** Category 1: 16 hours. **Contact:** Charles E. Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** (217) 782-7711.

Geriatrics

Geriatrics
For: Physicians, other medical professionals. Symposium, September 14, 1:00-5:00 P.M. Lawrenceville, IL. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25.00. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Charles E. Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** (217) 782-7711.

Gynecology

Premenstrual Tension Syndrome
For: Physicians, other health professionals. Symposium, September 26, 1:00-5:20 P.M., DuQuoin, IL. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25.00. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Charles E. Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** (217) 782-7711.

Plastic Surgery

Plastic Surgery Nurses' Conference
For: Nurses, other health professionals. Conference, September 27, Springfield, IL. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25.00. **Reg. Limit:** None. **Credit:** 4 CEU's. **Contact:** Charles E. Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** (217) 782-7711.

Internal Medicine

Postgraduate Conference in Internal Medicine
For: Physicians. Symposium, September 26-27, 8:00 A.M.-5:00 P.M., Iowa City. **Sponsor:** University of Iowa College of Medicine, Continuing Medical Education, 285 Med Labs., Iowa City, IA 52242. **Fee:** $200. **Reg. Limit:** None. **Credit:** Category 1: 13 hours. **Contact:** R.M. Caplan, M.D. **Phone:** (319) 353-5763.

Rheumatology

Medical and Surgical Management of Arthritis
For: Practicing physicians. Seminar, September 13-20, St. Louis. **Sponsor:** Washington University School of Medicine, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $400. **Reg. Limit:** 50. Reg. Deadline: August 13. **Credit:** Category 1: 20 hours, AOA: 20 hours, AAFP Prescribed: 20 hours. **Contact:** Loretta Giacoletto, Administrative Coordinator. **Phone:** (800) 325-9862.

Infectious Disease

Infectious Disease Update
For: Physicians, other medical professionals. Symposium, September 12, 3:00-7:00 P.M. Quincy, IL. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25.00. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Charles E. Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** (217) 782-7711.

Cardiology/Nuclear Medicine/Radiology

10th Annual Nuclear Cardiology Symposium
For: Physicians in cardiology, radiology, and nuclear medicine. Symposium, September 18-20, Milwaukee, WI. **Co-Sponsors:** Cardiovascular Disease Program, Milwaukee Clinical Campus, School of Medicine, University of Wisconsin, 465B WARF Bldg.; 610 Walnut St., Madison, WI 53705. **Fee:** To Be Determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 20 hours; University of Wisconsin CEU's; voice credit—approx. 20 hours. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** (608) 263-2856.

Cardiology

Cardiothoracic/Laser
For: Physicians, nurses, medical students, and related paramedicals. Seminar, September 9, 5:30-6:30 p.m. **Place:** Northwestern University Medical School Alumni Center, 303 E. Chicago Ave. **Sponsor:** Northwestern Memorial Hospital Laser Committee. **Fee:** None. **Reg. Limit:** None. **Credit:** None. **Contact:** Elaine Brown. **Phone:** (312) 908-4480.

Neurology

Current Clinical Neurology: A Comprehensive Review
For: Neurologists, Psychiatrists & Neurosurgeons. Lecture, September 9-13. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $540. **Reg. Limit:** 90. **Credit:** Category I: 40 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800)621-4649 in Illinois; (800)621-4651 outside Illinois.

Psychiatry

Sexual Medicine
For: Psychiatrists General Family Practitoners. Lecture, September 11-13. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $335. **Reg. Limit:** 90. **Credit:** Category 1: 24 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Dermatology

Specialty Review in Dermatology
For: Dermatologists. Lecture, September 16-20. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $550. **Reg. Limit:** 90. **Credit:** Category 1: 34 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

General Practice/Family Practice

Folk Medicine and Refugees
For: Physicians, nurses, and other health professionals. Conference: September 26, Madison, Wisconsin. Co-sponsors: University of Wisconsin Extension-CME and Wisconsin Dept. of Health and Social Services, 465 WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** To Be Determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 6 hours, AAFP Prescribed: Approx. 6 hours, and University of Wisconsin CEU's: Approx. 6 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Radiology/Obstetrics & Gynecology

5th Annual Breast Imaging Conference
For: Radiologists, Radiologic Technologists and others interested in breast imaging. September 22-24, St. Petersburg Beach, FL. **Co-sponsors:** University of Wisconsin—Dept. of Surgery & The Ausonics Corporation, New Berlin, WI. **Fee:** To Be Determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 18 hours, University of Wisconsin CEU's: Approx. 18 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Otolaryngology

Otolaryngology Head and Neck Laser Workshop
For: Otolaryngologists, D.O.'s and D.O.V.'s. Workshop, September 8-10, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $1,000. **Reg. Limit:** 15. **Credit:** Category 1: 20 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Internal Medicine

Specialty Review in Endocrinolgy & Metabolism
For: Internists and Endocrinologists. Lecture, September 20-October 4. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $615. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649 in Illinois. Outside Illinois: (800) 621-4651.

Postgraduate Conference in Internal Medicine
For: Physicians. Symposium, September 26-27, 8:00 A.M.—5:00 P.M., Iowa City. **Sponsor:** University of Iowa College of Medicine, CME, 285 Med Labs, Iowa City, IA 52242. **Fee:** $200 **Reg. Limit:** None. **Credit:** Category 1: 13 hours.

Internal Medicine/Oncology
Specialty Review in Medical Oncology
For: Internists and Oncologists. Lecture, September 30-October 4. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $615. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Plastic Surgery
Plastic Surgery Nurses' Conference
For: Nurses, other health professionals. Conference, September 27, Springfield, IL. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25. **Reg. Limit:** None. **Credit:** 4 CEU's. **Contact:** Charles E. Osborne, Ed.D., Assistant Dean for CME. **Phone:** (217) 782-7711.

Rheumatology
Medical and Surgical Management of Arthritis
For: Practicing Physicians. Seminar, September 13-20, St. Louis. **Sponsor:** Washington University School of Medicine, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $400. **Reg. Limit:** 50. Reg. Deadline: August 13. **Credit:** Category 1: 20 hours; AOA: 20 hours; AAFP Prescribed: 20 hours. **Contact:** Loretta Giacoletto, Administrative Coordinator. **Phone:** (800) 325-9862.

OCTOBER

Cardiology
Practical Aspects of Vascular Disease
For: Physicians and other health professionals. Conference, October 4, Madison, Wisconsin. **Sponsor:** University of Wisconsin Medical School Departments of Family Medicine, Radiology and Surgery, 465 WARF Bldg., 610 Walnut, Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 7 hours; AOA Category 2-D, and University of Wisconsin CEU's: 7 hours. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** (608) 263-2856.

Echocardiography
For: Cardiologists, Echocardiographers, Field technical specialists. Course and Workshop, October 22-25, Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60610. **Fee:** $350. **Reg. Limit:** 250. **Credit:** Category I: 26 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Neurology
Clinical Neuroimmunology Conference
For: Neurologists. Course, October 31-November 2. **Sponsor:** The University of Chicago, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** AMA Category 1: To be determined. **Contact:** Marlene Goldberg, Conference Mgr. **Phone:** (312) 962-1056.

Psychiatry
The Psychiatric Interview
For: Psychiatrists. Course, October 18-20. **Sponsor:** The University of Chicago, 5841 Maryland, Box 139, Chicago, IL 60637. **Place:** Chicago Hilton and Towers. **Fee:** $375. **Reg. Limit:** None. **Credit:** AMA Category 1: 17 hours. **Contact:** Marlene Goldberg, Conference Mgr. **Phone:** (312) 962-1056.

Psychiatry/Pediatrics/Nutrition
Eating Disorders
For: Physicians and other health professionals. Conference, October 11-12. **Sponsor:** University of Wisconsin Department of Pediatrics; Eating Disorder Clinic-University of Wisconsin, 465 WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: To be determined; ADA: Pending; AOA Category 2-D; WNA Pending; and University of Wisconsin CEU's. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Critical Care
Fourth Annual Chicago Critical Care Symposium
For: Physicians and nurses and other health professionals. Lectures, Tutorials, October 10-13 at Chicago Marriott Hotel. **Sponsor:** The Chicago Medical School, University of Health Sciences, 3333 Green Bay Rd., North Chicago, IL 60064. **Fee:** Physicians: $375.; residents and allied health professionals: $250. **Reg. Limit:** None. Reg. Deadline: October 8. **Credit:** AAFP Prescribed: 24 hours; Category 1: 24 hours; ACCN: 24 hours pending approval; ACEP: 24 hours pending approval; AARP: 24 hours pending approval. **Contact:** Sybil Michaels. **Phone:** (312) 578-3292.

Nutrition/Oncology/General Practice
Frontiers of Nutrition and Cancer
For: Physicians and other health care professionals. Symposium, October 17-18. **Sponsors:** University of Wisconsin CME; Wisconsin Nutrition Council; Dept. of Nutritional Sciences, University of Wisconsin, Madison; Clinical Nutrition Center, University of Wisconsin-Madison; Medical College of Wisconsin, Milwaukee; American Cancer Society; and Wisconsin Dietetic Association. Address: 465B WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 11 hours; University of Wisconsin CEU's and AOA's: Approx. 11 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Otolaryngology
Otolaryngology Head and Neck Laser Workshop
For: Otolaryngologists, D.O.'s and D.O.V.'s. Workshop, October 6-8. **Sponsor:** Northwestern University Medical School, 301 East Chicago Avenue, Chicago, IL 60611. **Fee:** $1,000. **Reg. Limit:** 15. **Credit:** Category 1: 20 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Internal Medicine & Family Practice
Midwestern Conference on Health Care in the Elderly
For: Physicians, nurses, social workers, and nursing home administrators. Symposium, October 18-19; 8:00 a.m.—5:00 p.m. **Sponsor:** University of Iowa College of Medicine, Continuing Medical Education, 285 Med Labs, Iowa City, IA 52242. **Fee:** $150/M.D.'s, $75/allied health. **Reg. Limit:** None. **Credit:** Category 1: approx. 10 hours; nursing credit; nursing home administrator CEU's. **Contact:** R.M. Caplan, M.D. **Phone:** (319) 353-5763.

Rheumatology
Focus on Rheumatology-1985
For: Physicians and other health professionals. Conference, October 18-19. **Sponsor:** University of Wisconsin, CME and Department of Medicine, 465B WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 9 hours; AAFP Prescribed 8½ hours; AOA Category 2-D: 8½ hours; and University of Wisconsin CEU's: 9 hours.

Obstetrics/Gynecology
Blue Ribbon Baby: Quality Care from Conception to Birth
For: Ob/Gyn M.D.'s, RN's and Midwives. Lecture/Workshop, October 3-4, 8:00 A.M.—5:00 P.M., Oak Brook. **Sponsor:** Rush University, Continuing Medical Education, 600 S. Paulina, Chicago, IL 60612. **Fee:** None. **Credit:** Category 1: 12 hours; ACOG applied for. **Contact:** Barbara Trejo. **Phone:** (312) 942-7119.

Endocrinology
Encocrinology Conference
For: Physicians and other medical professionals. October 10, 1:00 p.m.-5:30 p.m., Lincoln, IL. **Sponsor:** Southern Illinois University School of Medicine. **Fee:** $25. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean for CME. **Phone:** (217) 782-7711.

Neurology/OB-GYN/Psychiatry/Plastic Surgery
China Explorers Cruise Medical Seminar at Sea
For: Physicians and other health care professionals. October 8-21. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $600. **Reg. Limit:** None. **Credit:** Category 1 and AAFP Prescribed: 60 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean for CME. **Phone:** (217) 782-7711.

Join us in learning the opportunities and procedures available to the individual physician and the DME in developing, implementing and evaluating resources to enhance self-directed CME. Interact with your colleagues; communicate with physicians who have experienced the individualized approach to CME.

Participate in the Thirteenth Annual Congress on CME

DATE: October 11-12, 1985
PLACE: Arlington Park Hilton, Arlington Heights, Illinois
CREDIT: Nine hours Category 1 AMA/PRA

Learn from the participative, informative discussion of self-directed learning as it relates to individual CME from keynote speaker:
Robert K. Richards, Ph.D., Assistant Dean, Associate Professor, Michigan State University, College of Human Medicine
Executive Vice-President of the Grand Rapids Area Medical Education Center, Grand Rapids, Michigan

Respond to the fundamentals of helping physicians learn from keynote speaker:
Alan B. Knox, Ph.D., Professor of Continuing and Vocational Education, University of Wisconsin, Madison, Wisconsin

Twenty-three educational workshops will address the overall theme of the Congress.
Discuss how to develop Personal Education Plans for Physicians ● Work with D-Base Record Keeping Systems for Community Hospital CME ● Match Teaching Methods/Techniques to Goals and Objectives ● Improve Self-Directed Learning in Your Hospital ● Study the Role of the DME in Self-Directed Learning ● Exercise your Use of Computers in the Administration of CME ● Develop a greater understanding of the traditional aspects of CME, such as the establishment of sound educational needs, goals, objectives and evaluation criteria.

For further information, please contact the ICCME, Twenty North Michigan, Suite 700, Chicago, IL., 60602.

EKG

(Continued from page 18)

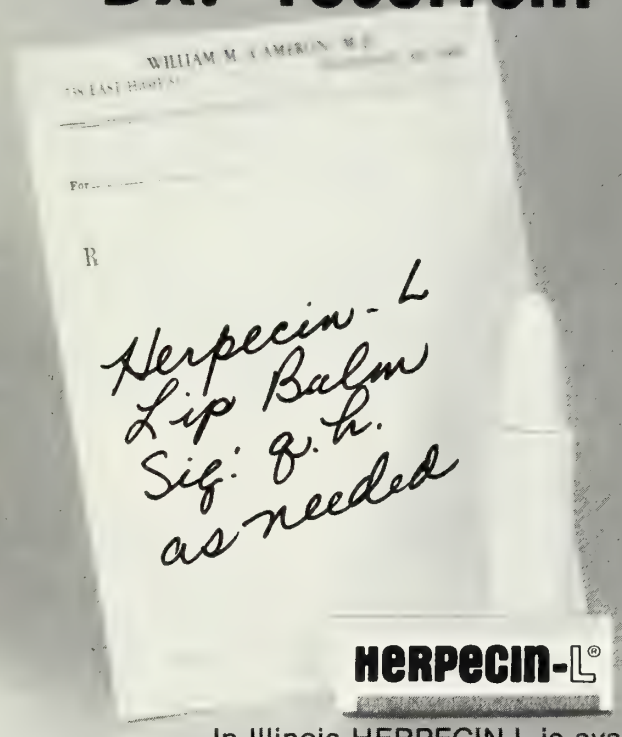
Answers: 1. A.D. 2. C.D.

Interpretation of this electrocardiogram is difficult because it requires clinical correlation. If the patient were asymptomatic, the tracing could be normal with high QRS voltage compatible with left ventricular hypertrophy. The stab wound in the left chest caused emergency room staff to consider acute pericarditis and hemopericardium. There was no pericardial friction rub heard and nothing to suggest pericardial tamponade. The chest x-ray was normal, as were the four views of the abdomen.

Pericarditis can cause ST segment elevation in all leads facing the epicardium as well as reciprocal ST changes. The ST segment in pericarditis then evolves on serial tracings eventually coming down to the baseline. Later T wave inversion develops to be followed by a normal ECG as the pericarditis resolves. Serial electrocardiograms in our patient were exactly the same as this first tracing. The ST segment elevation seen in early repolarization starts at the J junction and can be one to four millimeters elevated from the baseline with an upward concavity. A distinct notch can be seen on the downstroke of the R wave best seen here in leads V_3 to V_6. Tall T waves are often present. As seen here, these changes of early repolarization are often present in the mid-precordial leads. This electrocardiogram is a normal variant.

Observation of the patient in the hospital failed to show any worsening of his condition. A psychiatric consultant suggested the patient had an antisocial personality disorder with substance abuse. He was referred to the staff of the substance abuse and drug withdrawal program. ◀

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3 insertions	13.00	15.00	28.50	41.50
6 insertions	20.00	26.50	46.00	66.00
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EMERGENCY MEDICINE—Illinois and Missouri. Full and part time positions available in emergency departments and clinics for qualified physicians seeking lucrative employment opportunities. Outstanding remuneration and comprehensive malpractice insurance provided. For further information contact Amy Eisenman, Staffing Specialist. National Emergency Services, Inc., 1 Hollow Lane, Suite 304, Lake Success, New York 11042 or call (800) 645-4848.

U.S. AIR FORCE MEDICAL CORPS currently is accepting applications for physicians in the following specialties: Surgery (all specialties), Obstetrics/Gynecology, Otorhinolaryngology, Anesthesiology, Psychiatry, Orthopedic Surgery, Cardiology, Allergist, Family Practice, and Internal Medicine. For further information call collect: 1st Lt. Michael V. Vivoda: (312) 263-1207.

PHYSICIAN OPPORTUNITIES—Current openings for physicians of all specialities in the Illinois area and nationwide. Opportunities in solo, hospital and clinic based positions. For further information please contact Physician Recruiters Inc. at (312) 433-7180. All inquiries will be handled on a confidential basis.

ORTHOPAEDIC SURGEON with interest in Spinal Surgery to associate full/part-time with Chicago based Orthopaedic Group. Send C.V. to: Sports Medicine, Ltd. 6445 North Central Ave., Chicago, Ill. 60646.

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SOUTHERN ILLINOIS Family Practice for sale. Town of 12,000, fifteen miles from St. Louis, Missouri. Gross income 1983-$360,000.00 with no OB or Major Surgery. Office 5 blocks from major shopping center and 5 miles from nearest hospitals of 800 beds. Foreign medical graduates are welcome. Reply to Box #1131, c/o the *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

FOR SALE: SOLO FAMILY PRACTICE. Close to St. Louis. Two fully staffed hospitals. Community around 50,000. Well equipped office. Prime location and building. Average gross over $200,000 a year. Reply to Box #1169, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

ORTHOPEDIC SURGEON, board eligible or board certified wanted for established group practice in Chicago suburbs, excellent growth opportunity, generous compensation and benefits. Reply to Box #1168, c/o the *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

ILLINOIS: PEDIATRICIAN with thriving practice seeks BC/BE pediatrician full time/part time. Located 45 minutes west of downtown Chicago. Position available immediately. Please send CV to Box #1166, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

SOUTHERN CALIFORNIA. Prestigious HMO is seeking experienced specialists and general practitioners for our facilities in Los Angeles and Orange counties. Located in close proximity to major teaching centers, we offer the opportunity for continued professional development and rewarding clinical practice. Excellent compensation and benefits including paid malpractice, life, disability, medical and dental coverage, paid vacations, sick leave, educational leave and retirement plan. Please send C.V. to: Director/ Physician Recruitment, CIGNA Healthplans of California, 700 N. Brand Blvd., Suite 500-24, Glendale, CA 91203.

FAMILY PRACTITIONER. Marshfield Clinic Department of Family Medicine is seeking a BE/BC family practitioner for a new position. The physician joining the Clinic's expanding 5 member department will enjoy the support of one of the nation's largest multispecialty groups, share the philosophy of family-oriented care with a preventive focus, and enjoy full hospital privileges but without the distractions of OB or surgical responsibilities. Marshfield Clinic offers an excellent salary plus extensive fringe benefits. Send C.V. and the names of several references to: E. Grady Mills, M.D., Family Medicine Department Chairman; Marshfield Clinic, Marshfield, WI 54449, or call collect (715) 387-5168.

FAMILY PRACTITIONER/INTERNAL MEDICINE—To locate in Rosiclare, Illinois. 48 bed acute JCAH care facility located on the Ohio River in the beautiful foothills of Shawnee National Forest. Each physician is provided his/her own five room clinic adjacent to the hospital. Contact Roby Williams, Administrator, PO Box 467, Rosiclare, IL 62982. (618) 285-6634.

HOLISTIC DOCTOR. Compensation $25-30 per hour plus percentage. Solo practice. All equipment, personnel furnished. No start up fees. Excellent growth potential. Send C.V. & recent photo to: MLG Health Care Corporation, 1100 Wilmington Ave., Dayton, Ohio 45420.

ARIZONA BASED PHYSICIAN RECRUITMENT firm has opportunities coast to coast. "Professionals working with Professionals." Over 13 years experience. Call (602)-795-7474; or send CV to: Mitchell & Associates, Inc., 2761 N. Country Club Rd., Suite 202, Tucson, AZ 85716.

PHYSICIANS, LICENSED in Illinois, needed to do mobile insurance exams in the north and northwest suburbs. Call (312) 827-9777.

THE DEPARTMENT OF SURGERY at Cook County Hospital is seeking an attending physician in Adult Emergency Services. Position available, July 1, 1985. Attending physician needed for busy, urban public hospital Adult Emergency Services. BC/BE in Emergency Medicine or General Surgery. Cases limited to surgery. Previous teaching experience helpful. Cook County Hospital is an equal

opportunity employer. Please reply to: Olga Jonasson, M.D., Department of Surgery, Cook County Hospital, 1835 W. Harrison Street, Chicago, Illinois 60612.

INTERNIST—General internal medicine and geriatric medicine. Active general medical and surgical facility affiliated with University of Illinois at Champaign-Urbana, 35 miles distant. Federal fringe benefits include insurances, retirement/social security, vacation and sick leave, malpractice protection. $55,800-$80,300 range commensurate with background. License any state. English language proficiency required. Equal Opportunity Employer. Call or write W. L. Kannapel, M.D., Chief of Staff, VA Medical Center, 1900 E. Main St., Danville, IL 61832, (217)442-8000 × 563.

WANTED—A PRIMARY CARE PHYSICIAN licensed in Indiana to practice in University 38-bed JCAH accredited hospital for a 12-month fiscal year appointment. Must be able to communicate with and have empathy toward the college age population. Salary negotiable; excellent fringe benefits. Send resume to T. A. Schott, Administrator, Purdue Student Hospital, West Lafayette, Indiana 47907. An equal opportunity/affirmative action employer.

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EAR, NOSE, THROAT PRACTICE located in near NW suburb. Owner retiring. Practice grossing $100,000 on 20 hour work week, no surgery. Asking $50,000. Professional Practice Sales, 540 Frontage Rd., Northfield, IL 60093, (312)441-6111.

RETIRING CENTRAL ILLINOIS ORTHOPAEDIST desires board certified or board eligible orthopaedist to take over large general practice. Office completely furnished, x-ray, etc. Only expenditure would be for x-ray and office furnishings. Will introduce to referring physicians. (309)343-4177.

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PEDIATRIC PRACTICE FOR SALE in desirable suburb 60 miles northwest of Chicago. Call (312) 934-7265 after 6 p.m.

STUDENT HEALTH. Opening for primary care internist, family physician or pediatrician. Full-time 10 or 11-month position. Competitive salary and benefit package, 40-hour work week. Illinois license, board eligibility/certification, and interest in some gynecology required. Contact: Paul Nelson, MD, Student Health Service, Illinois State University, Normal, Illinois 61761, (309) 438-8655. Search will continue until position is filled. Preference will be given to those applying by Sept. 1, 1985. An Affirmative Action/Equal Opportunity Employer.

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SITUATIONS WANTED

AP/CP CERTIFIED, experienced, Illinois licensed pathologist available for locum tenens. Write to Box #1156, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602, or call (312) 835-0985.

ABIM—CERTIFIED INTERNIST desires suitable position, practice opportunity. Full license, well experienced in non-invasive cardiology. Reply to Box 1148, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

PGY1-GRADUATE of the University of Alexandria Egypt—speaks English and French fluently. Uncle is a surgeon in Illinois (U.S. citizen), will sponsor me. Seeking residency in any surgical specialty (general, E.N.T., ophthalmology, orthopedics, urology, ob.gyn., dermatology). All requirements will be complied with. Reply to Box 1167, c/o *Illinois Medical Journal.* Twenty North Michigan Avenue, Suite 700, Chicago IL 60602.

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FOR SALE: Thirty plus acres (about ¼ mile waterfront on lake) near Shell Lake, Wisconsin. Also for sale, 80 acres wooded property, and an acre waterfront lot near Cumberland, Wisconsin. Write: Bob Rieck, Box 277, Dupont, WA 98327, or call (206) 964-8645.

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RETIRING DOCTOR has many otolaryngological and ophthamological instruments for sale. Very reasonable. Suitable for private practice or hospital. Call (312) 863-6852.

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MISCELLANEOUS

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SORBITRATE®
(ISOSORBIDE DINITRATE)

Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks. Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis.

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites. Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established. If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension.

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE. The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy.

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary.

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur. Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory. The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined. However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals. On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months.

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers. In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal. The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly.

Information for Patients: Headache may occur during initial therapy with SORBITRATE. Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use.

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates.

Isosorbide dinitrate acts directly on vascular smooth muscle; therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug. A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet.

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose. There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman.

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established.

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related. In clinical trials at various doses, the following have been observed:

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent. Cutaneous vasodilation with flushing may occur. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur. Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg; for oral (swallowed) tablets, 5 to 20 mg; and for controlled-release forms, 40 mg.

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose. In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure.

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours. Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported.

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended. The extent to which development of tolerance should modify the dosage program has not been defined. *The oral controlled-release forms of isosorbide dinitrate should not be chewed.*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg); Chewable Tablets (5, 10 mg); Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg).

STUART PHARMACEUTICALS
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Speaking With One Voice



Everyone in medicine, regardless of specialty, is touched by the legal jeopardy of the malpractice threat. The universal nature of this threat undoubtedly is the major reason for the terrific cooperation of all doctors, spouses, and hospital personnel in the recent malpractice initiative, so ably organized by ISMS staff, which came to fruition on May 22nd with our Springfield rally.

Faced with this show of unity and depth of concern, the legislative leaders and Governor responded with a very favorable "leadership agreement." And the legislature passed it with some helpful amendments from some of our previous opponents in the legislature.

However, within an hour of the Governor's signing of the bill, trial lawyers had initiated a request before the circuit court of Cook County to declare portions of the bill unconstitutional. But it is hoped that the court's decision will be rendered promptly and favorably, since several other state supreme courts have handed down favorable decisions on similar bills in the last 10 years.

It was thrilling to see over 4,000 physicians and fair-minded friends in Springfield to put the necessary pressure on the legislature to accomplish most of our legislative goals. A natural corollary to this legislative success should be an expanded and more vital ISMS membership. I would urge all county societies, action team members and others involved in the recent legislative effort to remain active and channel these efforts into membership recruitment.

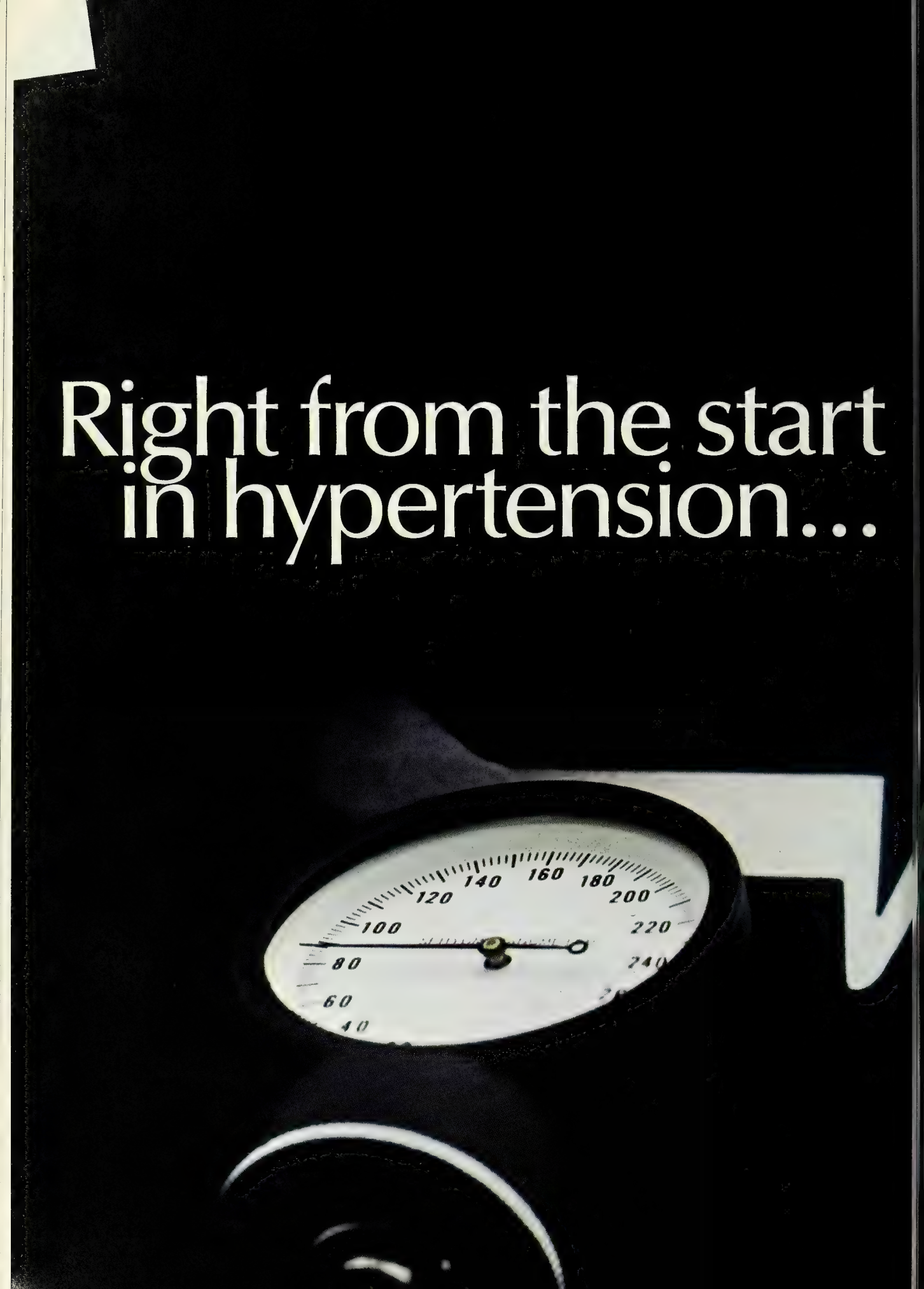
Here is another big challenge—convincing our practicing and teaching colleagues who are not members of organized medicine to join. An increase in the percentage of physicians who participate in organized medicine will bring about a corresponding increase in our credibility with the public, the media and the legislature.

The consequences of increased membership rolls will be a more equitable sharing of the financial burden of major public relations and legislative program costs. A larger base of dues paying members means better likelihood of containing escalation in the cost of membership dues. And it gives a broader base for effective education of the profession and the public with respect to the malpractice problem and our need for better negotiating tools to deal with government and other third party payors who are threatening the quality of patient care through their multiple devices of cost containment. ◂

Morgan M. Meyer

Morgan M. Meyer, M.D.
President

Right from the start in hypertension...



Once-daily INDERAL LA (propranolol HCl) for smooth blood pressure control without the potassium problems of diuretics

Once-daily INDERAL LA (propranolol HCl) avoids the risk of diuretic-induced ECG abnormalities due to hypokalemia.[1,2] In addition, INDERAL LA preserves potassium balance without additive agents or supplements while providing simple, well-tolerated therapy with broad cardiovascular benefits.

Once-daily INDERAL LA for the cardiovascular benefits of the world's leading beta blocker

Simply start with 80 mg once daily. Dosage may be increased to 120 mg to 160 mg once daily as needed to achieve additional control.

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

For beta-1/beta-2 blockade

Once-daily

INDERAL® LA

(PROPRANOLOL HCl) LONG ACTING CAPSULES



80 mg 120 mg 160 mg.

The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Please see brief summary of prescribing information on the next page for further details.

Once-daily
For beta-1/beta-2 blockade INDERAL® LA
(PROPRANOLOL HCl) LONG ACTING CAPSULES



The appearance of these capsules is a registered trademark of Ayerst Laboratories.

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block, hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium and decreased performance on neuropsychometrics

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea constipation, mesenteric arterial thrombosis, ischemic colitis

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress

Respiratory: bronchospasm

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS)

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use

REFERENCES

1. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768. **2.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299

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Teen Suicide

By Barbara Newman, M.A./Quincy
ISMSA Health Projects Coordinator

To family and friends, Tom (a pseudonym) seemed like a well-adjusted 14 year-old; a good student and a star tennis player at his Washington, D.C. school. Yet, last spring he tried to kill himself. Over a period of several months, Tom had become moody, lost his appetite, and could not sleep. He did not talk to anyone about his feelings. He kept up appearances despite increasing depression. When Tom's girlfriend, who did not like his behavior, broke up with him, he went home and swallowed a bottle of sleeping pills. Tom's parents found their son unconscious on the floor and rushed him to the emergency room. His life was saved, but an emotional struggle lay ahead. The ordeal left the whole family shocked and confused.

Why would a young person consider taking his own life? All adolescents undergo physical and emotional upheavals, but the current generation may face unprecedented pressures. Child psychiatrists note that today's young people are faced with more choices, greater freedom, and fewer limits than ever before. Not all of them can adjust.

Teenage depression may be intensified by a range of conflicts: family crisis, divorce, death of a parent or friend, peer pressure, parental pressure to achieve, a failed romance, or a move to a new neighborhood or school. Death may be viewed as an escape, a way to get attention or a means of expressing anger and revenge. A note left by a 13-year-old girl to her strict parents read simply: "Satisfied?"

One fact is clear: parents should not dismiss the impact of an adolescent crisis that seems trivial by adult standards.

The February *American Medical News* reported on a recent conference sponsored by Hartgrove Hospital, Chicago, exploring suicide prevention among teenagers. Dr. John Larson said he saw society's changing values as contributing to the increasing teenage suicide rate. The depressed adolescents he works with talk about how futile things seem. Dr. Larson noted that there is an incredibly striking correlation between drug use and suicide attempts. Today there is also sexual pressure from movies and television, which focus adolescents on superficial issues: their appearance and sex life. Prevention of suicide at the community level, he said, should start with medical professionals and counselors. Dr. Andrew Slaley, the keynote speaker, concluded: "In general, we don't need to feel hopeless about this mushrooming suicide rate. So much is associated with adolescent depression and adolescent depression picked up early can be treated!"

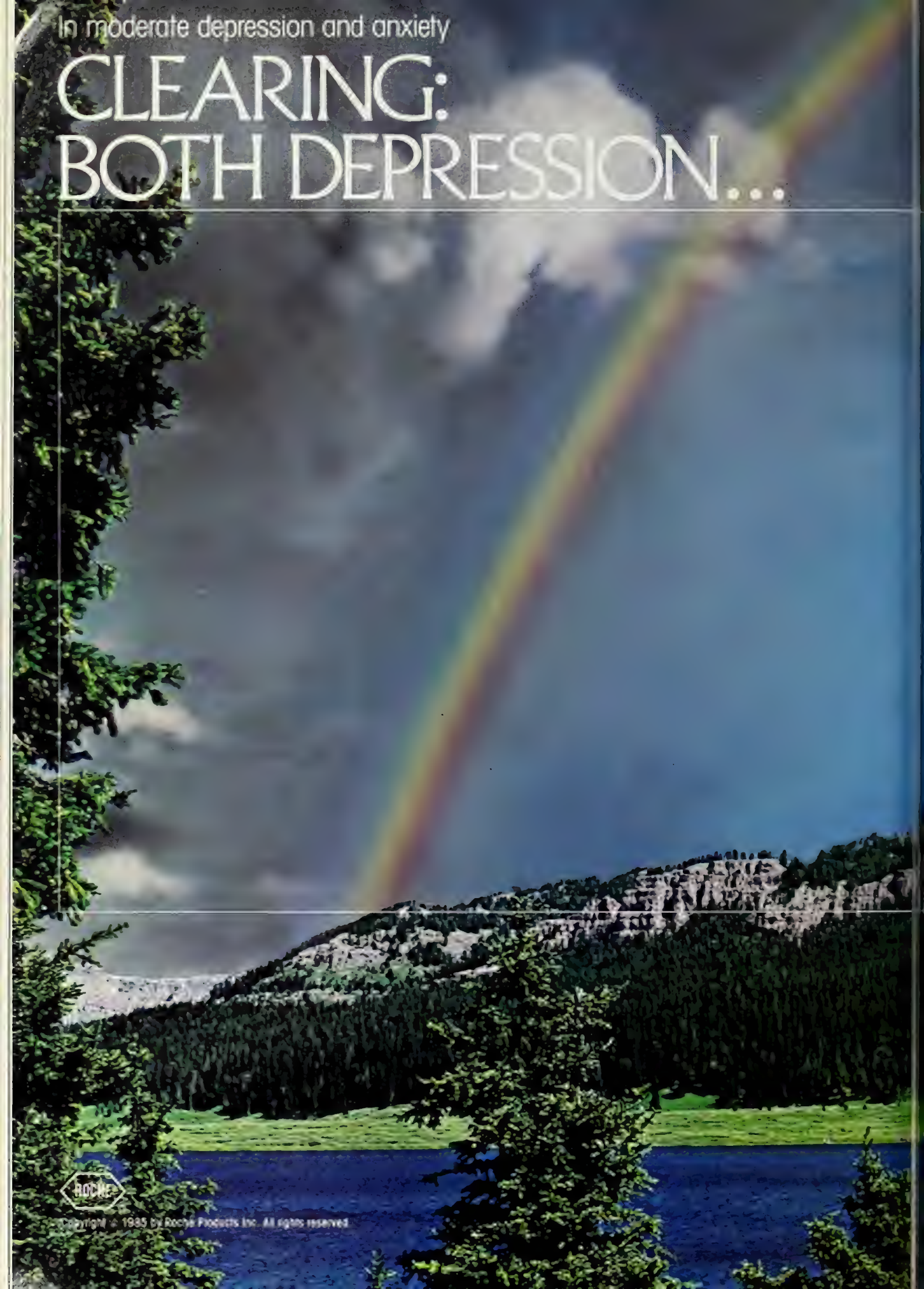
There are no easy answers, but there is hope. We can provide our schools with a comprehensive program on suicide prevention. Seminars can be offered to school personnel to train them to recognize changes in behavior or spot suicidal themes in writing assignments and artwork and to intervene with troubled teenagers. Parent workshops could provide specific information on how to cope with a child's potential suicide. In a special suicide prevention seminar, students could discuss their feelings about depression and suicide. Sources of help include local medical societies, child psychiatrists, pediatricians, family practitioners, school counselors and other mental health professionals.

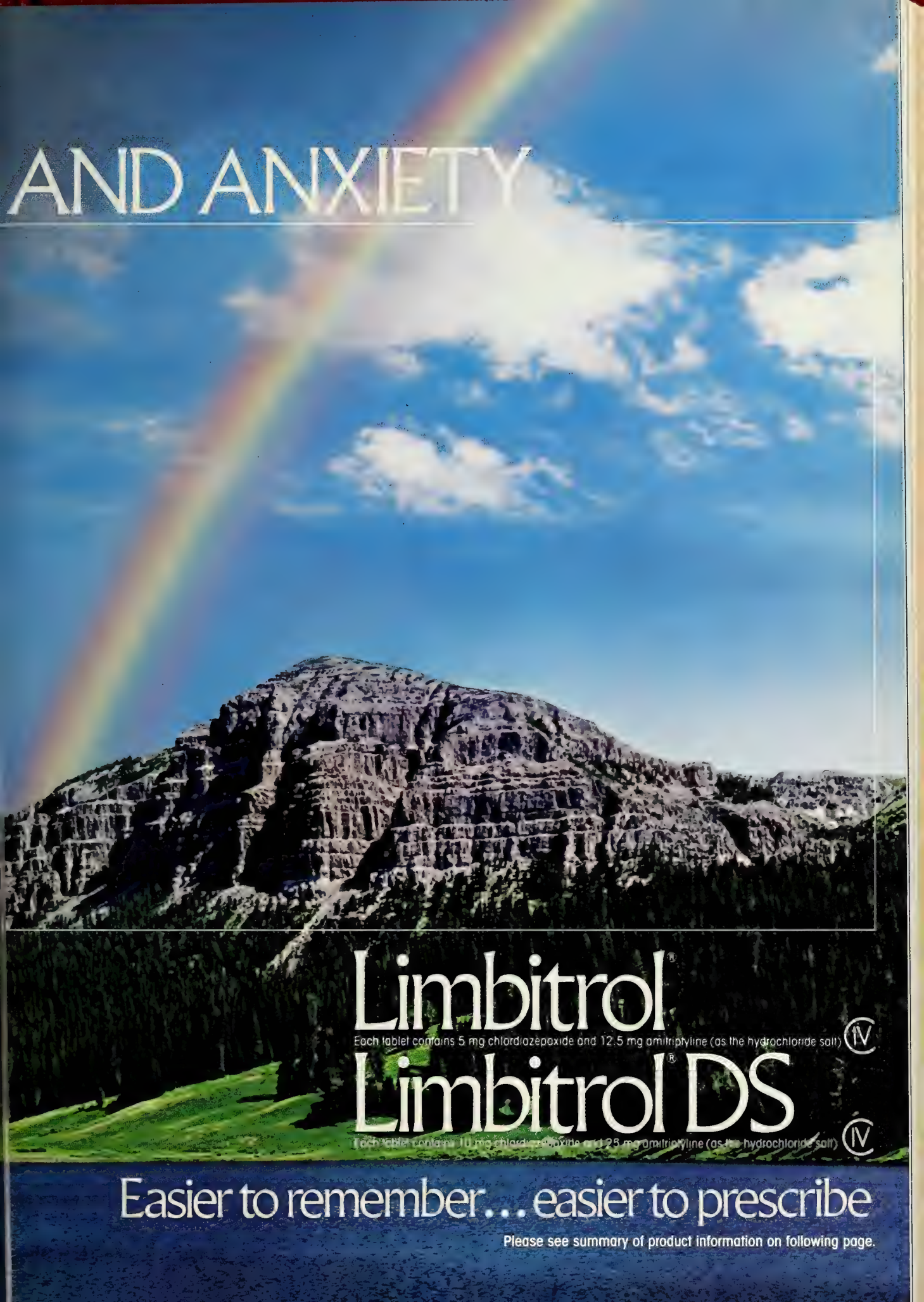
Coping with the potential suicide of a child places the entire family in crisis, but surviving the trauma together can strengthen family bonds. Remember Tom? By working with a psychiatrist the family found new ways to share and communicate with him. Today, Tom is doing well and not putting himself under so much pressure. He has learned he can bounce back after disappointments; he realizes he is loved and not alone.

With strong concern about the recent increase in teenage and child suicide throughout the United States, the American Academy of Child Psychiatry and the American Psychiatric Association have issued the following information about the warning signs of suicide in adolescents. These include many of the typical indications of the illness of depression:

- noticeable change in eating and sleeping habits;
- withdrawal from friends and family and from regular activities;
- persistent boredom;
- a decline in the quality of school work;
- violent or rebellious behavior;
- running away;
- drug and alcohol abuse;
- unusual neglect of personal appearance;
- difficulty concentrating;
- radical personality change;
- complaints about physical symptoms, often related to emotions, such as a stomach ache, headache, and fatigue;
- give verbal "hints" with statements such as "I won't be a problem for you much longer," "nothing matters," or "it's no use;"
- put his or her affairs in order—for example, give away favorite possessions, clean his or her room, or throw things away;
- become suddenly cheerful after a period of depression.

Nationwide, suicide is the number one preventable killer of our youth. The ISMSA wants to recognize and address this problem—to answer cries for help before it is too late. Won't you help us be the leaders in helping our children? ◀


In moderate depression and anxiety
CLEARING:
BOTH DEPRESSION...
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AND ANXIETY
Limbitrol®
Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)
Limbitrol® DS
Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)
Easier to remember... easier to prescribe
Please see summary of product information on following page.

Limbitrol® Ⓝ Tranquilizer-Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving)
***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide)
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated, sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.
Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: *Double strength (DS) Tablets,* white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets,* blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt). Available in bottles of 100 and 500; Tel-E-Dose® packages of 100, Prescription Paks of 50

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Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

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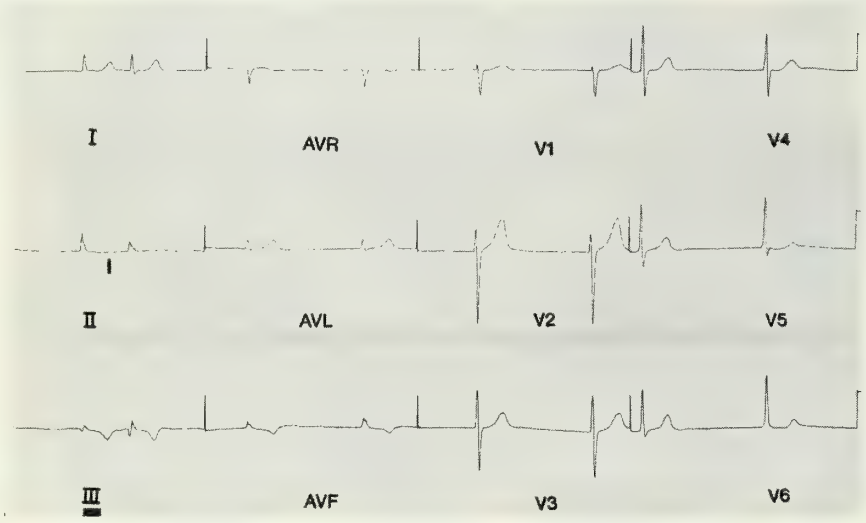
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Know Your CMR

EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This patient is a 69 year old man who had developed chest discomfort for the first time one month earlier. He described it as substernal pressure associated with nausea and a mild diaphoresis. The chest pressure lasted 15 minutes and did not radiate to his neck or arms. Subsequently, minimal exertion brought the same discomfort back, and the episodes became more frequent. He came to the hospital when an episode awakened him from sleep. The patient reported that he had undergone aorta-bifemoral cardiovascular surgery for severe claudication seven years before. His coronary risk factors were positive family history and 50 package per year cigarette smoking history. His heart and lungs were normal on physical examination but bilateral, carotid systolic bruits were found. He was admitted to the coronary care unit and treated with nitrates, propranolol, nifedipine, and heparin. Later, a coronary arteriogram demonstrated proximal obstructions of 90% in the right coronary artery, 75% in the left anterior descending, 90% in a diagonal artery, and 90% in an obtuse marginal artery. Left ventricular function was nearly normal with an ejection fraction of 52%. The next day the patient had another episode of chest pressure, his blood pressure fell to 80mmHg systolic, and this ECG was obtained.

Questions:

1. **The ECG shows:**
 a. Accelerated idioventricular rhythm.
 b. Junctional rhythm.
 c. Atrioventricular (AV) dissociation with severe sinus node dysfunction.
 d. Premature ventricular beats.
 e. Sinus or supraventricular capture beats.
2. **Which of the following statement(s) is/are true?**
 a. An acute myocardial infarction should be ruled out.
 b. The asymptomatic carotid bruits should now be evaluated.
 c. Intravenous atropine and/or dopamine might be helpful.
 d. Anti-anginal medications, *i.e.*, nitrates, propranolol, and nifedipine, should be increased.
 e. A temporary pacemaker is required.

(Continued on page 110)

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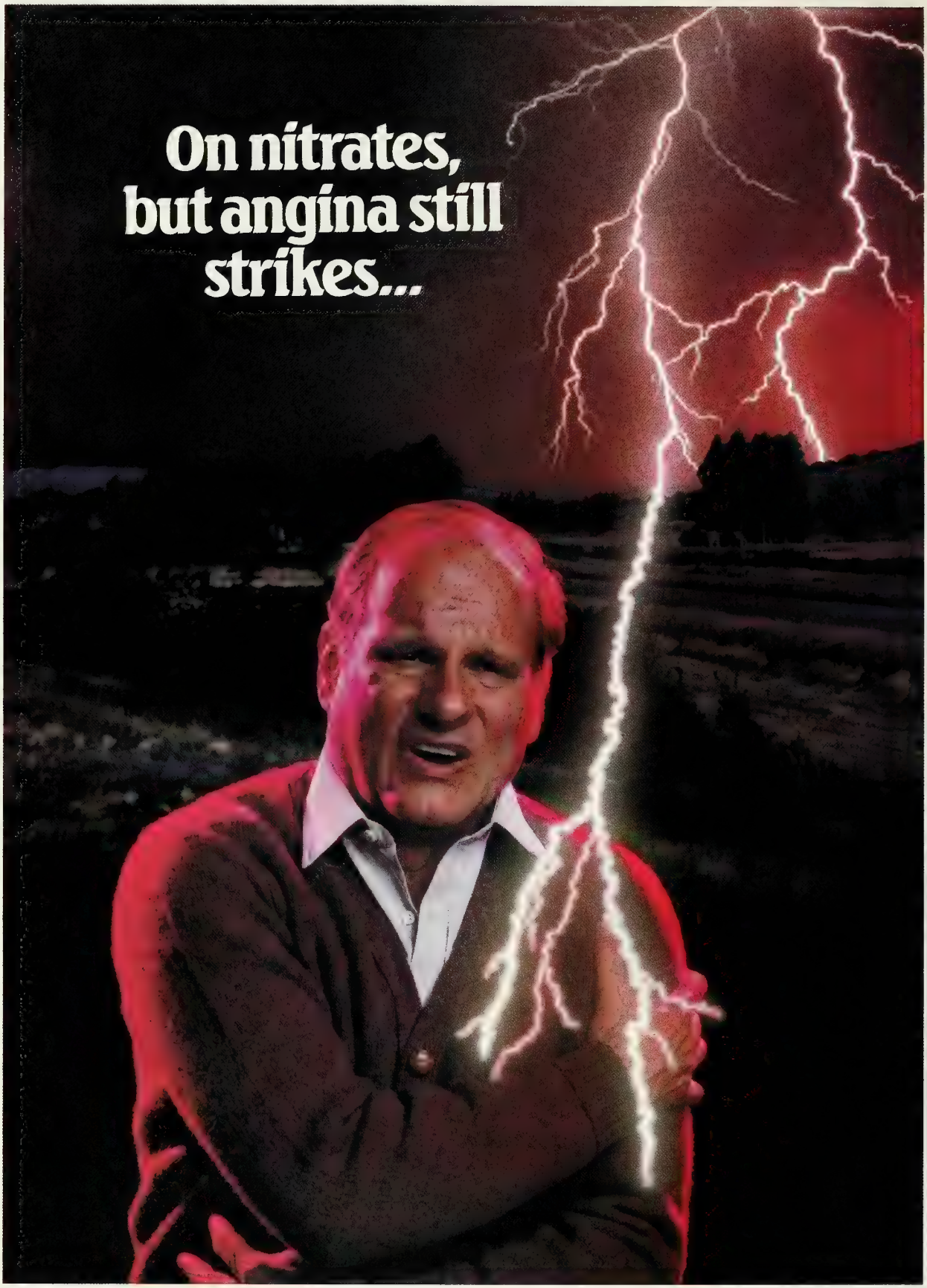
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Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.



ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN®
(verapamil HCl/Knoll)
80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings),* hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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President's Message

By Ehlma Garcia, CMA, EMT-A

It is a great pleasure and honor to be asked to write to you, the member, and to you, the physician/employer, to inform you of my goals as president for the year 1985-86 of the Illinois Society, American Association of Medical Assistants. My number one goal for the year is public relations/public awareness, followed by membership increase and education.

As you are aware, our organization is a tri-level, (national, state and local) non-profit, educational organization consisting of medical assistants, receptionists, nurses, emergency medical technicians and/or medical secretaries. In other words we are professionals who are employed by a physician, clinic or hospital.

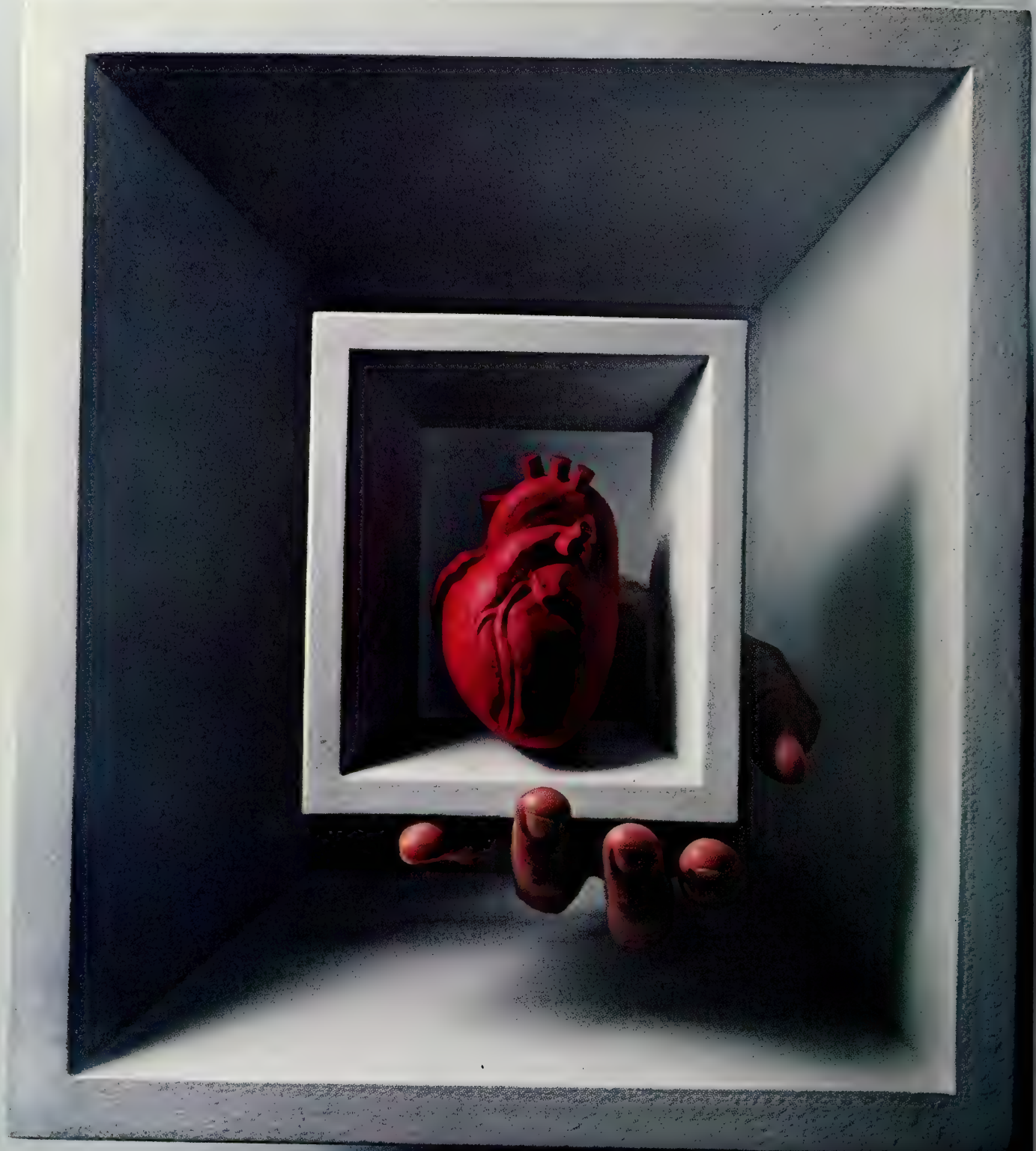
Many individuals (including some physicians) are not familiar with medical assistants or what services they are capable of performing. A medical assistant is trained to provide health maintenance to patients in a physician's office. Medical assistants administer medications, take vital signs, perform various laboratory tests, do ear lavaging, take electrocardiograms, do suture removal and assist with special procedures (pap smears, sigmoidoscope exams and minor surgery). These procedures are all under the supervision and the direct order of a physician. In addition to these clinical duties, medical assistants are skilled in administrative procedures as well. Skills such as billing procedures, insurance forms, bookkeeping, telephone techniques, making appointments, office management and inventory control are performed by the medical assistant.

As previously mentioned, my primary goal is public relations/public awareness, which will eventually demonstrate an increase in membership. The initial step for acquainting the medical assistant with her professional organization begins with her physician/employer. Many educational seminars are held throughout Illinois all year long. At the local level, the chapters meet on a monthly basis, at which time a lecture on billing procedures or first aid may be presented. Physician/employer, it is imperative that your medical assistant upgrade her medical knowledge to progress in the ever changing medical field. New procedures, equipment or techniques may shorten office hours and bring about a more smooth and productive practice.

As president, I urge you to allow me an opportunity to speak to your office personnel, medical schools, and/or hospitals during your monthly meetings to provide you with extensive information on the Illinois Society. The physician/employer is the main motivating force in introducing prospective members.

The public relations chairmen will be working hand-in-hand to contact local newspapers, radio and television stations. Upon accomplishing public awareness, membership increase will automatically follow suit. Consequently, public awareness is my primary goal. This must start within your own office, with your colleagues, your peers and your friends, making them fully aware of your medical assistant and the professional organization of which she is soon to be a member.

Information regarding the Illinois Society and/or medical assistants can be obtained from Ehlma Garcia, CMA, EMT-A, president, Illinois Society, 6134 South Tripp, Chicago, IL 60629; Robin Bluestein, CMA-C, co-chairman, Public Relations Committee, 2247 West Estes, #2, Chicago, IL 60645 or Catherine M. Hill, CMA, co-chairman, Public Relations Committee, 900 South Plum Grove Road, Palatine, IL 60067. ◀



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DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules
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INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood-pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of INDERAL LA capsules is a registered trademark of Ayerst Laboratories.

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ABSTRACTS OF ACTIONS

June 8-9, 1985 *ISMS Conference Complex*

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

Hospital Medical Staff Due Process

The IDPH Hospital Licensing Board is currently reviewing Rules on due process for medical staff members. Policies of ISMS should be considered. The principles need to be clearly established, for submittal to the Licensing Board.

The current Rule states that a medical staff's bylaws should provide: "For a policy that specifies a procedure for processing applications for staff privileges and guarantees due process and fair hearing for each such applicant." Last year, the Illinois Attorney General, in response to a request from the Hospital Licensing Board, interpreted that Rule as requiring all Illinois hospitals to provide full due process rights to *all* applicants for medical staff membership, as well as for current staff members. Another proposal was that the term "due process" and the due process rules should be removed from the Hospital Licensing Act. The ISMS Board took a position opposing removal of elements of due process from the rules.

The Board reviewed a new draft rule which incorporates the ISMS principles regarding the need for due process and the concern that hospitals have the discretion to determine the extent of due process provided to all applicants for medical staff membership, as well as for current staff members; and approved proposed language for a Hospital Licensing Board rule change on due process. The due process issue was referred to the Section on Hospital Medical Staffs for further review, and the Publications Committee was directed to include an article in the *Illinois Medical Journal.*

AIDS

On April 1, 1985, the Illinois Department of Public Health announced action to prohibit blood banks from reporting HTLV-III Antibody results to blood donors. The Board at its April, 1985, meeting, did not support this action. ISMS recommended an alternative approach for designated centers to do AIDS screening.

The Board amended its previous action on AIDS with the addition of the following: To extend all possible encouragement to members of high risk groups to continue to voluntarily disqualify themselves as donors; and that all blood and plasma centers be required to screen units and remove from the distribution system any units found to be HTLV-III positive; and while the ISMS is not opposed to the notification of donors, it reaffirms its position that all blood collecting facilities should delay notifying donors of the HTLV-III antibody test results until an alternative site testing system is in place or until a confirmatory test, more specific and sensitive, is developed, or the antibody test is replaced by a test for the antigen.

Cancer Detection Program

The Board reviewed a report on the development of an early cancer detection program. This program would focus on provision of diagnostic testing for physicians' families using mammography. This would be an educational tool to remind physicians of the significance of mammography in early detection. This would then encourage physicians to expand ordering of this diagnostic procedure.

The program will begin this fall and includes a mailing to all physicians in Illinois. Various educational items would be developed by the Cancer Society. In addition, the Auxiliary would also circulate the mailing to wives of physicians.

The Board agreed to support the concept of the early detection program and endorsed development and participation in the conduct of the program.

Other Actions

In addressing various other issues, the Board:

- Accepted the March 31, 1985, Financial Statements; May 24, 1985, IMPAC Collection Data; May 24, 1985, Dues Payment Report; and Requests for Changes in Membership Status.
- Directed that a subcommittee be established to further study Directors and Officers insurance with input from county medical societies that wish to be included, and report back to the Board of Trustees.

- Agreed to adopt the position and recommend to the Hospital Licensing Board (if and when the Licensing Board alters its rule to expand the types of practitioners who could serve as medical staff members) that rules permit those hospital medical staffs who want to include providers other than physicians on their staffs to do so, and allow establishment of an allied health staff if an individual hospital so chooses; and further recommended that the Section on Hospital Medical Staffs review this issue.
- Referred back to the Council on Education and Manpower for reconsideration, guidelines on funding of graduate medical education, with reference to the Health Policy Agenda of the AMA, and consideration of recommending a state trust fund.
- Agreed to hold an All-Member Conference in Peoria, November 2-3, in lieu of an Interim Session.
- Verified the elections of the following physicians to fill unexpired terms through December 31, 1985, as AMA Alternate Delegates: Drs. Albino Bismonte, Joan Cummings and Ulrich Danckers.
- Voted unanimously to oppose the proposed AMA dues increase for 1986.
- Discussed draft legislation from the Department of Registration and Education amending the Medical Practice Act and the Hospital Licensing Act, to allow appropriate neuropsychiatric examination in licensure and disciplinary proceedings; and directed that the chairman name a committee/task force to evaluate: (1) professional discipline; and (2) a search for medical coordinator.
- Approved legislative positions delineated in a primary list of House and Senate bills of interest to ISMS.
- Referred the IDPH regulation stipulating nonphysician membership and voting rights on a hospital's pharmacy and therapeutics committee to the Medical/Legal Council.
- Agreed to contact those members who attended the ISMS Legislative Rally in Springfield to encourage their membership in IMPAC.
- Approved the following eight 1986 travel programs for ISMS members: East Africa Air Safari, Western Caribbean Air/Sea Cruise, Spain Discovery, Alps to the North Sea Adventure, Adriatic/Mediterranean Air/Sea Cruise, Journey of the Czars Adventure, Scandinavian Capitals Air/Sea Cruise; and Expo/Alaska Air/Sea Cruise.
- Approved the following meeting schedule for 1986:

 House of Delegates
 April 4-6, 1986 (Annual Meeting)
 Nov. 8-9, 1986 (Interim Meeting or Member Conference)
 Board of Trustees
 Jan. 25-26, 1986
 Apr. 3-6, 1986
 Jun. 21-22, 1986
 Sep. 27-28, 1986

Nominations and Appointments

Various appointments and nominations were approved or ratified by the Board, as follows:

- Nominated Drs. Vincent Costanzo and Dorothy Hubler for reappointment to the IDPH Technical Advisory Council, Drug Product Selection.
- Ratified appointment of ISMS members to one-year terms on the society's councils and committees for 1985-1986.
- Council chairmen appointed for 1985-86 were: Drs. Fred Z. White, Chillicothe, Council on Economics; Eugene B. Loftin, Fairfield, Council on Education and Manpower; Joseph Purpura, Lake Forest, Governmental Affairs Council; Donal D. O'Sullivan, Oak Park, Medical Legal Council; Joseph D. Winterhalter, Jacksonville, Council on Medical Services; LeRoy Levitt, Chicago, Council on Mental Health and Addiction; and Albino Bismonte, Gurnee, Council on Public Relations and Membership Services.
- Appointed chairmen of committees reporting directly to the Board were: Drs. Terry F. Hatch, Urbana, Committee on CME Accreditation; Vincent A. Costanzo, Jr., Chicago, Committee on Drugs and Therapeutics; Fred Z. White, Chillicothe, Task Force on Financial Aid to Medical Students; Robert M. Vanecko, Chicago, Committee on Health Planning; L. Michael Newman, Evanston, Committee for the Impaired Physician: Donald Aaronson, Chicago, Ad Hoc Committee on Loss Prevention Education; and Boone Brackett, Oak Park, Peer Review Appeals Committee.

Program Sponsorship

The Board:

- Agreed to co-sponsor the Doctor's Job Fair to be conducted by Southern Illinois University School of Medicine, in September.
- Approved the listing of ISMS co-sponsorship on a news release from the Illinois Society for the Prevention of Blindness entitled, "Don't be Blinded by the Dangers of Fireworks."

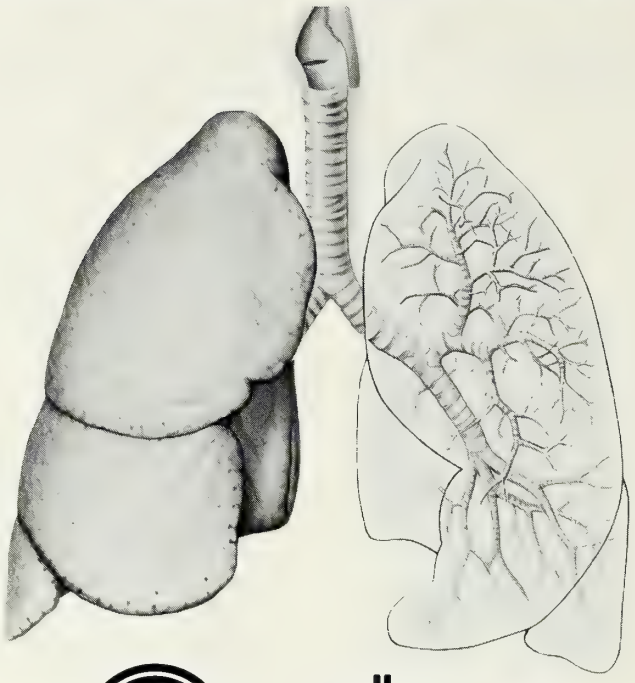
Information Items

The Board received a report from the Executive Administrator regarding the Springfield Rally, Professional Liability Initiative and PPO Legislation. A videotape on the legislative rally was presented for viewing by the Board of Trustees.

Next Meeting

The next Board meeting was set for September 28-29, 1985. ◀

Consider the causative organisms...



Ceclor®
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250-mg Pulvules® t.i.d.

offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, *H. influenzae*, *S. pneumoniae*, *S. pyogenes*
(ampicillin-susceptible) **(ampicillin-resistant)**

Brief Summary. Consult the package literature for prescribing information

Indications and Usage Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication. Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out

Precautions. *General Precautions* — If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers — Small amounts of Ceclor® (cefaclor, Lilly) have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0 18, 0 20, 0 21, and 0 16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[061782R]

Note Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information

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Angina comes in many forms...

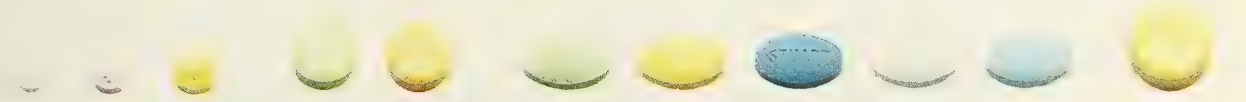


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(ISOSORBIDE DINITRATE)

Unsurpassed flexibility in nitrate therapy.



2.5 mg 5 mg 10 mg
Sublingual Tablets

5 mg 10 mg
Chewable Tablets

5 mg 10 mg 20 mg 30 mg 40 mg
Oral "Swallow" Tablets

40 mg
Sustained Action "Swallow" Tablets

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See following page for brief summary of prescribing information.

SORBITRATE®
(ISOSORBIDE DINITRATE)

Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks. Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites. Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established. If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension.

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE. The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy.

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary.

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur. Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory. The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined. However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals. On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months.

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers. In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal. The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly.

Information for Patients: Headache may occur during initial therapy with SORBITRATE. Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use.

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates

Isosorbide dinitrate acts directly on vascular smooth muscle; therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug. A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose. There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related. In clinical trials at various doses, the following have been observed

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent. Cutaneous vasodilation with flushing may occur. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur. Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg; for oral (swallowed) tablets, 5 to 20 mg; and for controlled-release forms, 40 mg.

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure.

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours. Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended. The extent to which development of tolerance should modify the dosage program has not been defined. *The oral controlled-release forms of isosorbide dinitrate should not be chewed*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg); Chewable Tablets (5, 10 mg); Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg)

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OBITUARIES

****Ball, Wilbur G.**, Carlock, died May 13, 1985 at the age of 76. Dr. Ball was a 1935 graduate of the University of Nebraska College of Medicine, Omaha.

***Buettner, James A.,** Barrington, died May 1, 1985 at the age of 64. Dr. Buettner was 1947 graduate of the Wayne State University School of Medicine, Detroit, Michigan.

***Coogan, Thomas J., Jr.,** Winnetka, died June 15, 1985 at the age of 52. Dr. Coogan was a 1958 graduate of the St. Louis University School of Medicine, St. Louis, Missouri.

***Ferrara, Thomas P.,** Chicago, died June 17, 1985 at the age of 43. Dr. Ferrara was a 1969 graduate of the College of Medicine and Dentistry of New Jersey—New Jersey Medical School, Newark.

****Sibilsky, Carl E.,** Peoria, died June 7, 1985 at the age of 85. Dr. Sibilsky was a 1926 graduate of the Medical College of Wisconsin, Milwaukee.

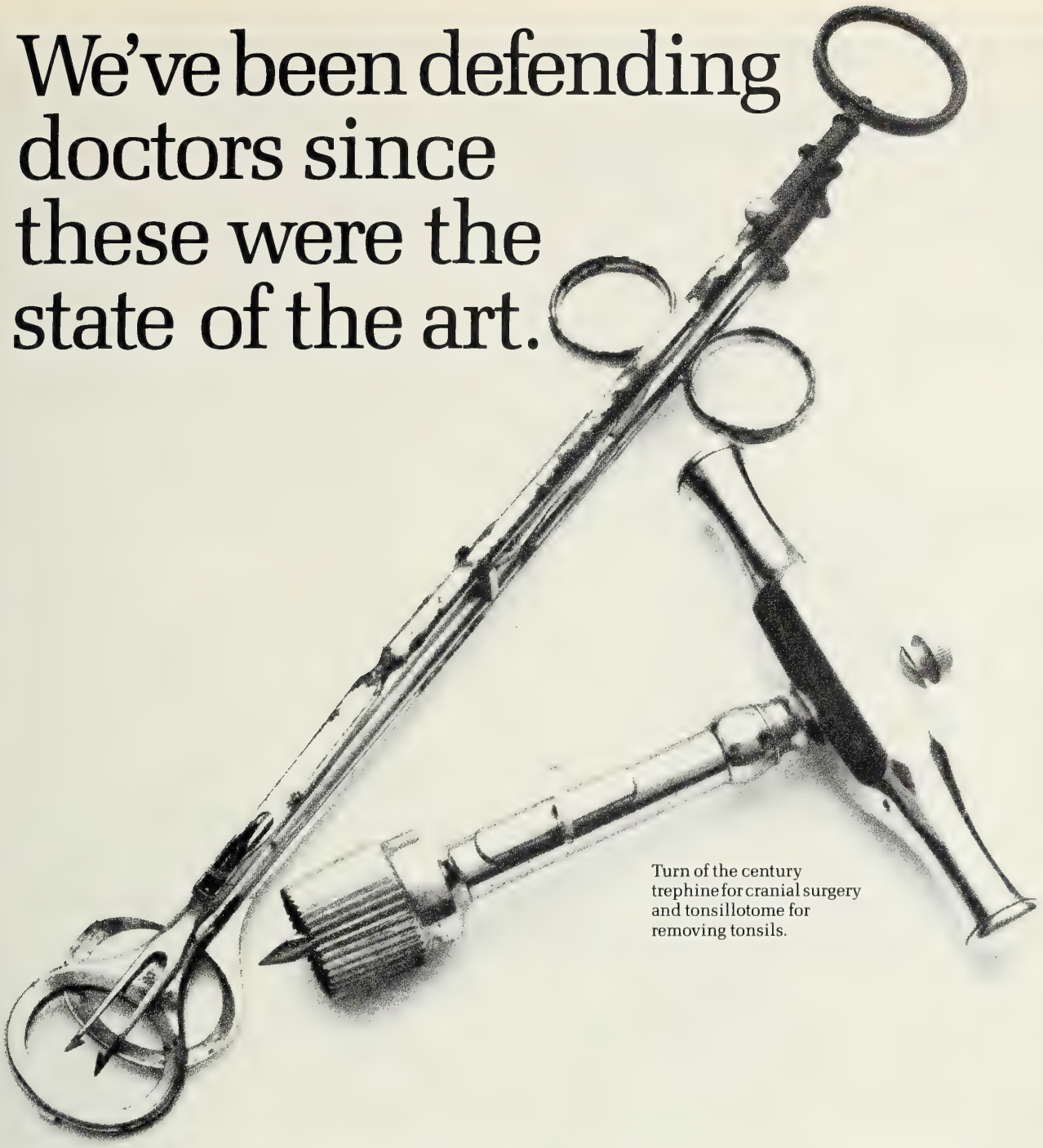
****Tatar, Joseph,** Highland Park, died May 23, 1985 at the age of 78. Dr. Tatar was a 1930 graduate of the Orvosi Fakultas Tudomanyegyetem, Debrecen, Hungary.

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Report of a First Year's Experience

Cardiac Transplantation

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Cardiac transplantation may now be considered an acceptable treatment for selected patients with end-stage heart disease. Survival rates improved to 80-90% in the first year since cyclosporine was introduced as a primary immunosuppressive agent. We report our first year's experience with eleven procedures. All patients were discharged within one month of the transplant. Two patients died six weeks and 2.5 months after the transplant. The remaining nine have resumed normal physical activity. The availability of cardiac transplantation is contingent upon recognition of potential donors and successful procurement of those organs.

Introduction

The first cardiac transplant, performed by Dr. Christiaan Barnard in Capetown, South Africa, on December 3, 1967,[1] excited the world. Over 100 such operations were performed on three continents during the following year. Unfortunately, the ensuing one year survival rate of only 22% led to rapid disenchantment and virtual abandonment of this procedure for the therapy of end-stage heart disease.

The diligent work of personnel at several cardiac surgical centers, especially that of Dr. Norman Shumway and his colleagues at Stanford University, resulted in an improved one year survival rate of 63% by 1980.[2] The reasons for this improved survival rate include: standardization of donor and recipient criteria;[3] development of routine endomyocardial biopsy to identify rejection histologically;[4] standardization of the primary immunosuppressive protocols and those designed to treat acute rejection; an aggressive approach to the infectious complications of cardiac transplantation;[5] and finally, better control of chronic allograft atherosclerosis,[6] the serious manifestation of chronic rejection, by the use of low cholesterol diets and anti-platelet agents. The greater availability of this operation was made feasible with the development of programs for distant organ procurement,[7] myocardial preservation with cold potassium cardioplegic agents,[8] and national computer hot lines for distribution of organs.

More recently, cyclosporine,[9] a selective immunosuppressive agent, has been incorporated into primary immunosuppressive protocols. This has resulted in further improved survival rates, so that current expectations approach a one year survival rate in excess of 80%.[10] Patients who have undergone successful cardiac transplantation are no longer subject to the functional and hemodynamic[11] limitations that characterized their previous cardiac disease. At this writing, 91% of these patients are completely rehabilitated.[12]

These advances have taken cardiac transplantation from medical curiosity to acceptable alternative therapy for patients with end-stage cardiac disease. As a result of these impressive statistics, it is anticipated that cardiac transplantation will be utilized for the therapy of many more patients with end-stage heart disease. Our facility has developed a large cardiovascular referral population. We have recently added heart transplantation to our therapeutic armamentarium for heart disease. This was considered a logical extension of the high volume

cardiovascular surgical program and active kidney and bone marrow transplant programs. This report summarizes the results of the first eleven cardiac transplants performed at our facility, including the first cardiac transplant performed in the state of Illinois in 15 years.

Patient #1:

The first patient was a 21-year-old white male with oculocutaneous albinism who had been healthy and active until he developed bronchitis and low grade fever. Within one month he noted and reported easy fatigue to his family physician. At initial evaluation, physical examination revealed cardiomegaly with an audible S3. Chest x-ray showed cardiomegaly with pulmonary vascular redistribution. The 12-lead EKG showed left ventricular hypertrophy with premature ventricular beats. After referral to a cardiologist, he had a radionuclide ventriculographic ejection fraction of 12% in the left ventricle. Cardiac catheterization demonstrated normal pressures, but a decreased cardiac index of only 1.4 $l/min/m^2$ and left ventriculography showed a markedly enlarged diffusely hypokinetic left ventricle. Coronary arteries were normal. An endomyocardial biopsy was performed to rule out myocarditis. There was no evidence of inflammatory infiltration, yet the histology was abnormal. Prominent endocardial and perivascular fibrosis, irregular myocyte hypertrophy accompanied by nuclear enlargement, and hyperchromaticity compatible with dilated cardiomyopathy were noted.

Despite marked hemodynamic impairment, medical management with digitalis, diuretics, and vasodilators stabilized the patient so that he could return to work. Three months later he developed a febrile illness with nausea and diarrhea. Severe refractory congestive heart failure ensued within two weeks. He was placed on dobutamine and nitroprusside to maintain cardiac output. Despite these medical interventions his left ventricular ejection fraction was less than 10%. Echocardiogram showed marked left ventricular enlargement (end diastolic dimension 8.6cm) with poor wall motion. A right heart catheterization on dobutamine and nitroprusside showed a right atrial pressure of 20mmHg, right ventricular pressure of 55/20mmHg, pulmonary artery pressure of 55/23mmHg with a mean of 35mmHg, and the mean pulmonary arterial wedge pressure of 28mmHg. Cardiac output was 2.8/l/min, and the pulmonary vascular resistance 2.5 Wood units. Because of the absence of a reversible myocardial lesion (myocarditis) and the presence of severe refractory heart failure that was dobutamine and nitroprusside dependent, the patient was considered for cardiac transplantation.

Three days after notifying the Illinois Transplant Society, an appropriate donor was found, and surgery was performed. The patient was prepared for surgery by the administration of methylprednisolone 500mg IV, equine antithymocyte globulin (ATGAM) 5mg/Kg IV, and cyclosporine 10mg/Kg. The donor cardiectomy was performed in the donor hospital by a team consisting of two cardiac surgeons and coordinated by the donor organ procurement team. While the donor cardiectomy was being performed, two cardiac surgeons prepared the recipient by exposing the heart and cannulating for cardiopulmonary bypass. Once the donor heart was in the operating room, the recipient cardiectomy was completed and the donor heart sutured in place. Surgery lasted 3.5 hours. Total ischemic time for the allograft was 125 minutes and it took 47 minutes to suture the new heart in place.

Upon completion of anastomoses the allograft contracted spontaneously and the patient was supported on low dose isoproterenol. The immediate postoperative period was entirely uncomplicated. The patient was extubated on the first postoperative day, and the chest tubes were removed 48 hours after surgery. A ten-day course of ATG was infused and the dose of cyclosporine was adjusted to maintain the trough serum level between 100ng/ml and 250ng/ml. The corticosteroid dose was tapered to prednisone 0.3mg/Kg within two weeks of surgery. The patient enjoyed an immediate sense of well-being. He was exercising on a defined physical therapy program which included upright bicycle exercise within five days of surgery.

Endomyocardial biopsies were performed at weekly intervals and mild rejection was identified 20 days after the initial surgical procedure. This was successfully treated with two courses of pulse methylprednisolone 1g IV daily X3. A pericardial effusion accummulated in the early postoperative period requiring chest tube reinsertion and drainage of 1300cc of serous fluid. Although this fluid slowly reaccummulated over the next month, there was no hemodynamic compromise. The effusion resolved spontaneously 3.5 months postoperatively. At 29 days after surgery endomyocardial biopsy showed no evidence of rejection. Hemodynamics were normal with a cardiac output of 6.0 l/min, and a radionuclide ejection fraction of 69%. The patient was discharged on the 31st postoperative day.

Over the following month two episodes of moderate rejection were noted on surveillance endomyocardial biopsies. To treat the first, the maintenance prednisone dose was increased to 1mg/Kg. For the second, a short course of ATG was prescribed. The patient is totally asymptomatic fourteen months following transplant, with no evidence of rejection. He has returned to work and school. The patient developed only mild hypertension from the cyclosporine, which has been successfully treated with nifedipine. He jogs three miles and rides his bicycle 5-10 miles daily.

Patient #2:

The second patient was a 37-year-old white male who was well until he developed substernal chest discomfort resulting in an acute antero-septal myocardial infarction. This was complicated by congestive heart failure and persistent pain, necessitating intra-aortic balloon counterpulsation. He underwent cardiac catheterization and coronary angiography which demonstrated significant disease in the left anterior descending and obtuse marginal branches of the left coronary artery. Subsequently, he had

double aorto-coronary bypass grafting to those vessels and did well for several months. Over the following two years, however, slowly progressive congestive heart failure ensued. As a result, he was no longer able to work.

A follow-up cardiac catheterization demonstrated patent coronary artery bypass grafts with progressive severe left ventricular dysfunction and enlargement. Despite digitalis, diuretics, and anticoagulants, he was unable to carry out even non-strenuous activity and was referred for cardiac transplantation.

Evaluation at our facility showed cardiomegaly on chest x-ray and left bundle branch block on ECG. Radionuclide ejection fraction was 14% in the left ventricle and his echocardiogram showed left ventricular enlargement with poor wall motion. He was only able to perform three minutes and 13 seconds of exercise on a Naughton protocol. Right heart catheterization with a flow directed catheter showed a mean pulmonary arterial wedge pressure of 25mmHg and a cardiac index of 2.3 l/min/m^2.

Because of his large size (100kg), it took three months to find an adequate donor. The patient was prepared with immunosuppression, and underwent orthotopic cardiac transplantation. The allograft ischemic time was 110 minutes. A severely fibrous left ventricle encased in a thickened pericardium with extensive adhesions was found at surgery. The patient was extubated on the first postoperative day and chest tubes removed 36 hours later.

The postoperative course was complicated only by mild renal dysfunction with elevation of serum creatinine to 3.0mg/dl and blood urine nitrogen to 102mg/dl on the fourth postoperative day. It was felt that cyclosporine nephrotoxicity was responsible. By the seventh postoperative day, parameters of renal function had normalized and the BUN had decreased to 52mg/dl with creatinine to 1.1mg/dl. The patient was discharged from the hospital 28 days following surgery. He is feeling well and is physically active, returning to full-time employment 11 months after surgery.

Patient #3:

The third patient was a 46-year-old white male who had been healthy until he developed a viral syndrome with laryngitis, cough, fever and hoarseness. Within one week of onset, he developed ascites and peripheral edema, reporting exertional dyspnea and easy fatigue requiring further evaluation. The patient was a former cigarette smoker and social drinker with no history of diabetes or hypertension and unremarkable family history. On physical examination he was normotensive with no jugular venous distention. His lungs showed decreased breath sounds in the right base with a right pleural effusion. He had an S3 and S4 gallop and a grade 3/6 holosystolic murmur with a displaced apex beat. His abdomen was distended with ascites and his liver was enlarged several centimeters below the right costal border. His EKG showed left bundle branch block, right axis deviation and first degree AV block. His chest x-ray showed cardiomegaly with blunting of the right costophrenic angle.

Non-invasive evaluation included an echocardiogram which demonstrated left ventricular enlargement with severe left ventricular dysfunction and normal valvular motion. Radionuclide ventriculography showed an ejection fraction of 20% in the left ventricle. Twenty-four hour ambulatory monitoring showed frequent premature atrial contractions, episodes of sinus slowing with junctional escape beats and salvos of atrial ectopic rhythm. There were frequent multi-focal premature ventricular contractions and occasional couplets. Treadmill exercise performance showed only 3′30″ exercise capacity on a Bruce protocol.

At cardiac catheterization and coronary angiography, his hemodynamics showed a left ventricular end diastolic pressure of 26mmHg and a mean pulmonary capillary wedge of 30mmHg. Pulmonary artery pressure was 45/30mmHg with a mean of 35mmHg. The mean right atrial pressure was 16mmHg. His cardiac index was 1.6 l/min/m^2, and pulmonary arterial resistance was 1.5 Wood units. Coronary arteries were normal. The following day he underwent right ventricular endomyocardial biopsy which demonstrated endocardial fibrosis and irregular myocyte hypertrophy in the absence of active myocarditis. Upon completion of the evaluation and in preparation for cardiac transplant, he underwent vocal cord biopsy which showed only hyperplasia and had dental surgery to repair his poor dentition.

After a compatible donor was identified, and the patient underwent orthotopic cardiac transplantation using the immunosuppressive protocol outlined in previous cases. The immediate postoperative course was entirely uncomplicated. He had no evidence of renal dysfunction following his transplant. He was extubated on the first postoperative day; his chest tubes were removed on the second postoperative day. Exercise protocol involving bicycle exercise was initiated the seventh postoperative day. The 23rd postoperative day, he developed atrial flutter as a manifestation of biopsy-proven acute rejection. The rejection was managed by pulse methylprednisolone and the arrhythmia with quinidine and overdrive pacing. He was discharged on the 31st postoperative day. At three months, the patient was feeling well on a regular physical exercise program and had returned to full-time employment.

Addendum

Our first year's experience of eleven cardiac transplantation procedures has been completed (Table 1). The mean age of our recipients was 40.9 ± 11.2 years. Five of these patients had dilated cardiomyopathy. Five had had ischemic left ventricular dysfunction secondary to multiple myocardial infarctions (three of whom had undergone previous coronary bypass surgery and/or aneurysmectomy). One patient had severe aortic regurgitation secondary to bacterial endocarditis that prompted aortic valve replacement. However, left ventricular dysfunction persisted which was refractory to medical therapy.

Seven of these patients were severely hemodynamically compromised and required dobutamine inotropic support prior to the

transplant. The mean pulmonary arterial systolic pressure was 49.0 ± 15.3mmHg and pulmonary artery wedge pressure was 25.2 ± 10.1mmHg for the group. The mean cardiac index was 2.4 ± 0.6 L/min/m^2 despite the fact that these measurements were recorded while dobutamine was infused in seven of the eleven patients. The mean left ventricular end diastolic dimension measured echocardiographically was markedly increased at 7.1 ± 0.9cm. The mean radionuclide left ventricular ejection fraction was markedly decreased at 11.8 ± 3.0%. The mean donor age for the group was 25.4 ± 7.3 years.

Seven of the eleven patients received their allografts from local donors and four received their allografts from distant donors (Indianapolis, IN; Rochester, NY; Fayetteville, NC; and Atlanta, GA). All patients survived the initial hospitalization with a mean length of stay of 26.8 ± 2.8 days. In the follow-up period, 1.09 rejection episodes per patient were identified that were successfully treated. Infectious complications occurred in eight patients. One had bacterial pneumonia, another had oral candidiasis and mucocutaneous herpes simplex infections occurred in two patients. Four patients had cytomegaloviral infections; three of these were asymptomatic and detected by routine viral titer measurement while one resulted in CMV chorioretinitis. Pericardial effusions were noted in three patients and two patients experienced a post pericardiotomy syndrome. Systemic hypertension, a common complication of cyclosporine therapy, was noted in 10 of 11 patients. Steroid induced diabetes was identified in two patients. One patient suffered a brief psychotic episode probably related to high-dose corticosteroid and another patient had a single generalized seizure on his seventh postoperative day that was felt to be due to cyclosporine therapy. He was treated with phenytoin and has had no recurrence of this seizure disorder. On follow-up, two patients expired of acute rejection, six weeks and 2.5 months post transplant, respectively. The remaining nine patients are alive and well; six have returned to full-time employment. One patient is returning to school and another has opted on his own volition not to return to full-time employment. The final patient is only two months postoperative and anticipates a return to part-time employment within the next month. Of the nine patients surviving, eight of them are New York Heart Association functional Class I, one patient is New York Heart Association functional Class II who reports fatigue on extreme exertion. These patients have maintained a rigorous physical exercise program. The first patient transplanted, who is currently fourteen months post transplant, follows a rigorous weight lifting program and jogs regularly five to six miles per day. Currently, there are five patients on the active transplant list awaiting suitable donors.

Table 1
Cardiac Transplantation—1984

Patient	Age	Diagnosis	Hospitalization	Outcome
1	21	DC	31 days	NYHA Cl I
2	37	Ischemic LVF	26 days	NYHA Cl I
3	46	DC	32 days	NYHA Cl II
4	46	DC	26 days	Died 2½ mos
5	22	Valvular Disease	25 days	NYHA Cl I
6	36	DC	25 days	NYHA Cl I
7	50	DC	26 days	NYHA Cl I
8	41	Ischemic LVF	26 days	NYHA Cl I
9	52	Ischemic LVF	23 days	NYHA Cl I
10	55	Ischemic LVF	27 days	Died 6 weeks
11	44	Ischemic LVF	24 days	NYHA Cl I

DC = dilated cardiomyopathy; LVF = left ventricular failure; NYHA Cl = New York Heart Association functional class

Table 2
Cardiac Transplant Program
Recipient Criteria

1. Terminal heart disease not correctable by medical or surgical therapy
2. Age: 16-55 years
3. NYHA Class III-IV
4. Pulmonary vascular resistance 6 Wood units or less
5. Stable psychosocial status
6. Lack of active infection, recent pulmonary infarct (within six weeks), malignancy, or irreversible liver or kidney damage
7. Absence of drug or alcohol abuse

Discussion

Although the first human cardiac transplant was performed in 1967,[1] this procedure was considered experimental until only recently, when major advances resulted in acceptable mortality rates. Ideal candidates for cardiac transplantation could not be defined until large numbers of patients had undergone the procedure.

Current recipient criteria incorporated into our cardiac transplant program are listed in Table 2. Individuals with (1) terminal heart disease not correctable by known medical or surgical therapy; (2) a documented poor survival rate and (3) suffering symptoms in New York Heart Association Class III or IV, are considered potential candidates. Although the age range for these individuals is usually between 16 and 55 years of age, transplantation can be considered in selected patients above 55 or younger than 16. Because a normal right ventricle is implanted into the recipient, fixed pulmonary vascular resistence of less than six Wood units is required; otherwise the donor's right heart would be unable to provide adequate cardiac output through a high resistence pulmonary circuit. Because long term medication is necessary with potent

immunosuppressive agents, a stable psychosocial status with absence of drug or alcohol abuse is desirable. The presence of active infection or pulmonary infarction would heighten the likelihood of infection immediately following a transplant, when the corticosteroid dose is highest. Insulin dependent diabetes is considered a relative contraindication because of the great fluctuations in glucose typically seen when corticosteroids are used in high doses. The presence of a malignancy or irreversible liver or kidney damage would prevent long term survival in these patients, who should otherwise be limited only by their cardiovascular disease. Most patients who come to cardiac transplantation, therefore, have either coronary artery disease with irreversible severe left ventricular dysfunction or idiopathic dilated cardiomyopathy. In Stanford's large experience, when allograft survival was compared in these two patient population groups, there were no differences in the success rate of transplants dependent upon etiology of pre-existent heart disease.[13]

Donor criteria were standardized after data was accummulated identifying the ideal heart donor. Donor criteria are listed in Table 3. Once brain death is pronounced, a donor is considered if less than 30 years of age without evidence of chest trauma, history of cardiac disease, infection, or malignancy. A normal EKG and chest x-ray are required. Previous cardiopulmonary resuscitation is a contraindication for heart donation because CPR may result in cardiac contusion. For optimal function of the allograft, only low doses of vasopressors for less than 24 hours are allowed. Most heart donors come from a population killed in motorcycle or automobile accidents or those who sustained gunshot wounds to the head. Once a potential donor is established, the ideal recipient for that donor would be matched according to body size (± 25% of body weight) and ABO compatibility. A donor specific cross-match is then obtained. In this assay, serum from the recipient is incubated with donor lymphocytes and complement. In the absence of evidence of lysis of donor lymphocytes by preformed antibodies in the potential recipient serum, the likelihood of a hyperacute reaction is remote and the transplant can proceed.

Table 3
Criteria For Heart Donor

1. Age 14-30 male; 16-35 female
2. ABO compatibility
3. No cardiac arrest (evaluate closely)
4. No traumatic chest injuries
 No chest tubes
5. Chest x-ray
 No pneumonia
 No atelectasis
 "Normal" heart shadow
 No severe pulmonary edema
6. No EKG abnormalities, disease, recent ischemia, congenital abnormalities
7. Cardiology consult (auscultate for abnormalities)
8. May require echocardiogram
9. Use of vasopressors: Dopamine
 < 10mcg/Kg/min < 24 hours
10. Prior cross-match required
11. No evidence of infection

In the early days of clinical heart transplantation, identification of rejection was a major problem. Inferences from the animal model suggested that electrocardiographic voltage changes correlated with rejection and this tool was used clinically for several years. In 1972, routine endomyocardial biopsy was included in the protocol at Stanford.[4] This technique, which is safe and can be performed easily on outpatients, allows the frequent evaluation of immunosuppressive therapy by following histology. This became even more important after cyclosporine was introduced as a primary immunosuppressive drug, because the myocardial edema resulting in a decrease in EKG voltage is not prominent and previously described EKG criteria for rejection are no longer valid. In our medical center this procedure has been routinely employed for the evaluation of patients with heart disease of unknown cause. Over 600 of these procedures have been performed without major complications.[14]

Prior to December of 1980, prednisone and azathioprine were considered the primary immunosuppressive drugs of choice in prevention of cardiac allograft rejection. More recently, cyclosporine, an immunosuppressive drug which affects the communication between the helper lymphocyte and the cytotoxic cell by decreasing the production of interleukin-2, has been utilized in clinical heart transplantation. Because of its specificity in affecting cytotoxic lymphocytes, this agent does not affect clearance of organisms causing suppurative infections. Cyclosporine allows the dose of corticosteroids to be rapidly tapered. The incidence of life

Table 4
Immunosuppressive Therapy Protocol*

Immediately Pretransplant:

Cyclosporine 10mg/Kg P.O.
ATG (horse) 5mg/Kg I.V.
Methylprednisolone 500mg I.V.

At Time of Donor Heart Support:

Methylprednisolone 500mg I.V.

First Day Post-Transplant:

Methylprednisolone 125mg × 3 I.V.
Cyclosporine 10mg/Kg.
ATG 5mg/Kg.

Day 2 Post-Transplant and Beyond:

Cyclosporine: Dose altered to maintain trough levels at approximately 200ng/ml.
Mean maintenance dose = 6.3 ± 3.0mg/Kg/d

ATG: Total T-lymphocyte count maintained at approximately 200 LY/mm^3.
Discontinued day 10.

Prednisone 1mg/Kg P.O., tapered by 0.2mg/Kg/48 hours to 0.2mg/Kg maintenance.

**Modified Papworth Protocol (Ref #16)*

threatening bacterial infection has declined dramatically since its introduction. Cyclosporine therapy improved survival and decreased infection rates, and subsequently decreased the cost of the procedure by lessening the mean hospitalization from three months to four-six weeks. The effect of cyclosporine can be said to change rejection from an acute, overwhelming process to a more smoldering process, resulting in easier manageability with less toxic agents. Long term effects of cyclosporine as a primary immunosuppressive drug in cardiac transplantation, however, cannot yet be assessed because experience with this agent is so brief.

Cyclosporine is not without its complications. Hypertension occurs in most heart transplant recipients and a dose dependent hepatotoxicity may occur. This hepatotoxicity can be obviated by carefully monitoring cyclosporine blood levels so that the drug is given in a sub-toxic dose.[15]

The initial experience with cyclosporine showed a prominent nephrotoxic effect with creatinines rising to a level requiring dialysis in some recipients. With further experience, however, the initial dose of cyclosporine has been decreased and given as an oral preparation rather than intravenous bolus so that kidney toxicity may be minimized. Because of the nephrotoxicity, we chose an immunosuppressive protocol modified from the Papworth Hospital in Cambridge, England, whereby antithymocyte globulin (ATG) in low doses is used during the first 10 days post-transplant so that cyclosporine can be initiated in a relatively low loading dose.[16]

Our immunosuppressive protocol is included in Table 4. Early protocols using cyclosporine included initial doses as high as 18mg/Kg. Our protocol calling for 10mg/Kg has resulted in minimal reversible nephrotoxicity in only one of our patients (Patient #2). Other serious side-effects of the use of cyclosporine may be a slight increase in the incidence of lymphoma compared to the known 1%-5% incidence quoted in immunosuppressed transplant patients. Despite its potential toxicities, this agent can clearly be considered an advance in the armamentarium of the transplant immunologist for the prevention of organ rejection.

Summary

As a logical extension of our cardiovascular surgery and renal and bone marrow transplant programs, we have developed a cardiac transplantation program and report the results of our first year's experience. The success that many centers are experiencing today demonstrates that cardiac transplantation has progressed from the status of an experimental procedure to that of a viable alternative in therapy of end-stage cardiac disease.

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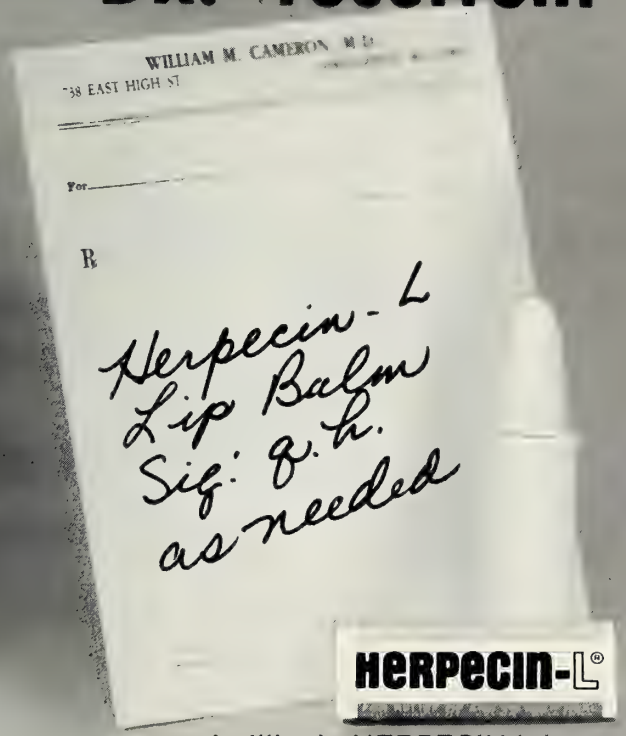
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Report of a Case

Carcinoma in a Parathyroid Cyst

By James Gordon Wright, M.D., and
Robert W. Brangle, M.D.,/Maywood and St. Louis, Missouri

This case report details the care of a patient with hyperparathyroidism who was found to have carcinoma in a parathyroid cyst. This is believed to be the first report in the literature of a malignant parathyroid cyst.

A 60-year-old retired minister was admitted with a right anterior cervical mass, persistent hypercalcemia and hypophosphatemia. Fifteen months before admission, his serum calcium, phosphorus concentrations and physical examination had been normal. Malaise, polyuria, polydipsia and a painless neck mass had troubled the patient for the last 12 months. Three times during the three months before admission, the concentration of total calcium and inorganic phosphorus in his serum had been found to be above 14.0mg and below 2.0mg per 100ml of serum, respectively. During the two months before admission the patient developed a mild, high esophageal dysphagia of solid foods.

Physical examination revealed a lean, normotensive elderly and cooperative man with a smooth, 5cm right paratracheal mass. The mass seemed to be fused to the right inferior pole of the thyroid. It extended into the substernal space and moved with deglutination. His voice was strong and clear.

Pertinent laboratory data included the following values: Hematocrit 40.2%, total serum calcium 13.8mg, inorganic phosphorus 2.2mg, serum albumin 3.9gm, and total protein 7.0gm/100ml. The serum alkaline phosphatase measured 107mU/ml and serum chloride 109mEq per liter and the patient was euthyroid. The immunoreactive PTH was 2,317mU/ml (normal: 230-630mU/ml).

Roentgenograms of the skull were normal. A technetium 99m pertechnetate thyroid scan revealed a 4.5cm cold mass on the right lobe of the thyroid. Ultrasonograms of the pretracheal region showed that the mass was multicystic. (Figure 1)

The patient underwent cervical exploration. A large, soft cystic mass was found. The mass engulfed the right recurrent laryngeal nerve and adhered to both the right lobe of the thyroid and the right carotid and internal jugular sheaths. The mass was removed by *en bloc* resection of the isthmus and right lobe of the thyroid. Dissection and extirpation were extremely difficult.

Grossly, the lesion measured 4.6 × 3.1 × 2.0cm and was multicystic. Microscopic examination revealed nests and trabeculae of parathyroid cells separated by thick collagen bands. Also seen were widespread vascular invasion, a mitosis involving parathyroid cells and the microscopic criteria for parathyroid cysts. (Figures 2 and 3)

Clinical follow up four years after surgery revealed a calcium level of 9.7mg/100ml of serum, and a PHT level of 400mU per liter of serum. Neither symptoms nor phys-

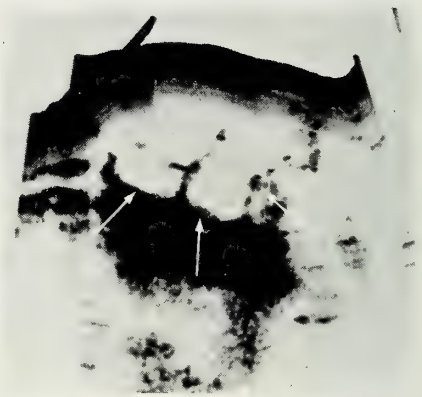


Figure 1.
Ultrasonogram of the pretracheal region, 2cm to the right of midline near the right inferior lobe of the thyroid. Arrows line the posterior aspect of the multicystic sonolucent region.

ical exam showed clinical evidence of recurrence.

Comment

Carcinoma of the parathyroid is a rare disease. At this writing, 142 cervical and 16 mediastinal cysts had been reported in the literature.[1,2] It comprises 1%-4% of all cases of hyperparathyroidism,[3,4] and eventuates most commonly between the ages of 30 and 60.[3,4] In contrast to parathyroid adenomas, which occur two[5] to three[6] times more often in women, parathyroid carcinomas occur slightly more often in men.[3,4,7] In a well accepted review of 70 parathyroid carcinoma cases, Schantz and Castleman[4] proposed clinical and morphologic features which (in the absence of metastasis) help to distinguish parathyroid carcinoma from parathyroid adenoma. These include: (1) a palpable tumor, especially in a male; (2) a high serum calcium level (>14mg%); (3) the operative finding of gross fibrous adhesions onto surrounding neck structures; (4) microscopic fibrous trabeculae throughout the gland; (5) parenchymal mitotic figures; and (6) capsule or blood vessel invasion.

Clinically significant parathyroid cysts are also rare. Of 158 reported cases,[8,9] only 10% produced hyperparathyroidism.[4] None of the previously reported cases were found to be malignant. Parathyroid cysts generally occur about twice as often in women as in men. The subset of *functioning* parathyroid cysts, however, occur about twice as often in men as in women.[9]

In both men and women, a parathyroid cyst commonly presents as a painless neck mass near the inferior aspect of the thyroid. Several authors agree on the following morphologic criteria for parathyroid cysts:[9] (1) the presence of normal parathyroid tissue within the cyst wall; (2) a cyst lining of cuboidal or low columnar epithelium; and (3) location of the tumor within the normal location of the parathyroid glands.

There are four theories of parathyroid cyst pathogenesis. These postulate either a congenital or an acquired mechanism of cyst formation. Authors who favor the theory of congenital pathology depict cysts as enlarged embryonal remnants of the third branchial cleft.[2,10] Those who support theories of acquired pathology[10] depict cyst formation as being either: (1) idiopathic enlargement of "normal" cysts (colloid containing parathyroid vesicles have been found in 84 of 100 consecutive autopsies);[11] (2) coalescence of microcysts; or (3) degeneration of parathyroid adenomas. Whatever their origin, parathyroid cysts have never been reported with simultaneous malignancy.

It cannot be ascertained whether this case represents two separate lesions arising independently in the same parathyroid gland, or a cystic change caused by a parathyroid carcinoma, or even an (approximately) one percent incidence of parathyroid carcinoma occurring in regular association with parathyroid cysts. However, we can state that parathyroid cysts are sometimes malignant. With this fact in mind, perhaps we may conclude that needle aspiration is not a rational means of affecting a cure of parathyroid cysts, as had been recently proposed.[8,9]

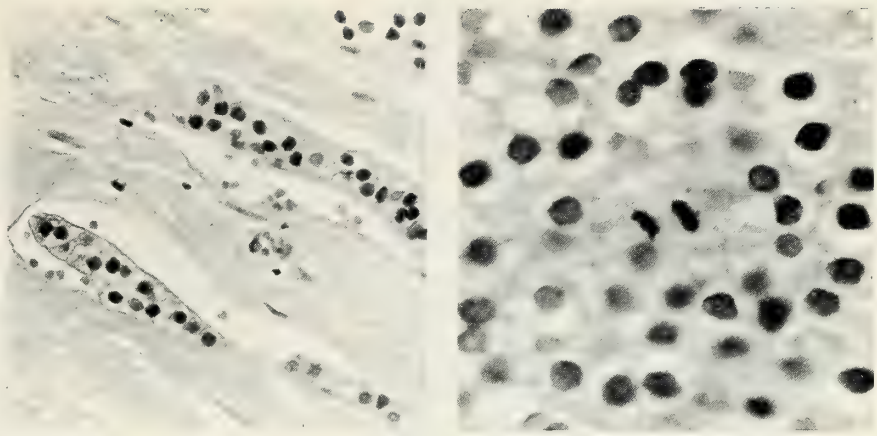


Figure 2.
(L) (Hematoxylin and eosin) Parathyroid cells attached to and present within blood vessels. (R) (Hematoxylin and eosin). A parathyroid parenchymal mitotic body.

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The authors respectfully acknowledge the expertise of both Arthur Dalton M.D., who provided excellent patient care, and Edward Paloyan M.D., who graciously advised us in the preparation of the manuscript.

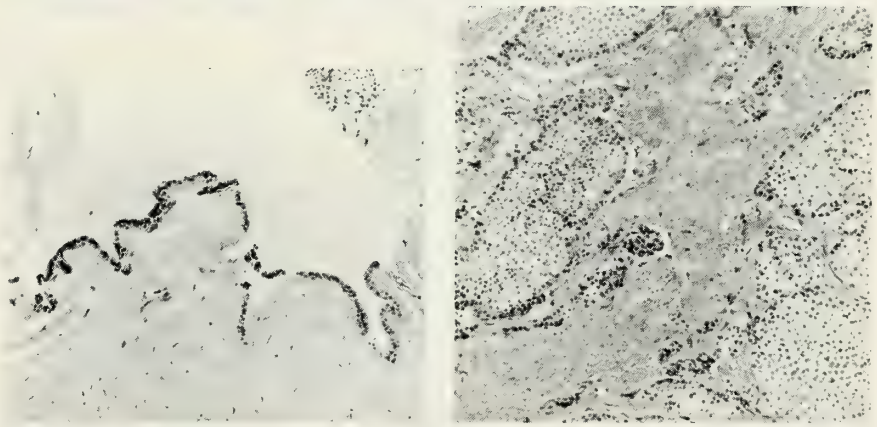


Figure 3.
(Hematoxylin and eosin) (L) A cyst wall lining of low columnar epithelium. In the upper right corner, normal parathyroid cells are seen within the cyst wall. (R) Bands of fibrous connective tissue separate nests of mature, uniform parathyroid cells.

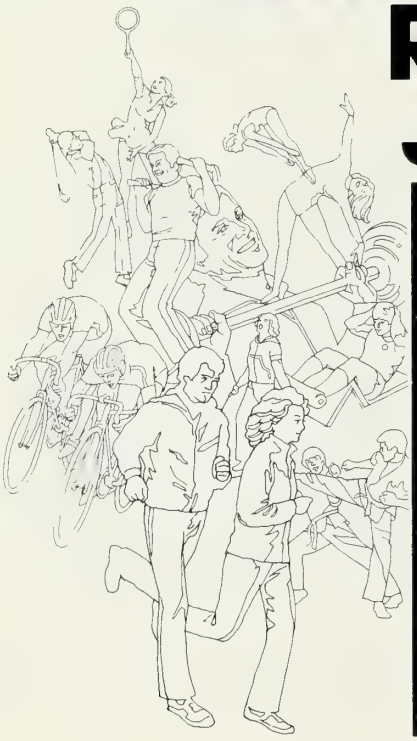
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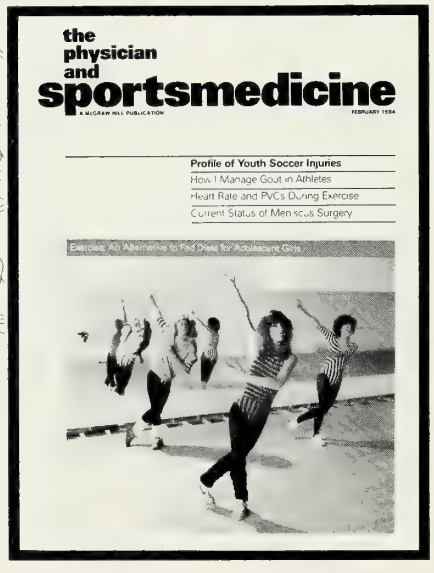
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Not Just a Check But a Chance

Gregory L. Coler became director of the Illinois Department of Public Aid (IDPA) in December, 1983, after five years of service as director of the Illinois Department of Children and Family Services. A native of Minnesota, he is former associate commissioner for the New York State Department of Social Services and a former executive director of the National Council of Organizations for Children and Youth.

IMJ talked to Director Coler about his experiences to date and plans for the future of IDPA.

IMJ: ***What were your initial goals as director of IDPA?***

Dir. Coler: The Governor wanted me to make sure that the Department of Public Aid was an institution that conveyed a sense of humanity to the people of Illinois. IDPA has the largest departmental budget in the state: a $3.4 billion budget has been appropriated for this year. Directly or indirectly, public aid touches a lot of lives in this state. That includes not only those who receive the aid, but the thousands of businessmen who do business with the department.

A huge institution like this can easily become a towering babble of technological information, churning out tens of thousands of eligibility forms. It's pretty easy to forget that individual who is down on his luck. One overall goal was to get the focus back. We wanted to bring the rich resources of this department to focus on the individual's problem and to bring him or her from a state of dependence to independence.



IMJ: ***But isn't administration of such a huge institution an overwhelming task?***

Dir. Coler: It's fun. I have an unbridled enthusiasm for what I do. I am very happy that I am able to discharge the responsibilities of the office. I consider it a real privilege to serve in this chair, and I really like my job a lot. That's important because it is a difficult job; there are a lot of pressures. If one didn't like it, there wouldn't be a lot of sense in trying to do it.

But the challenge for a department of this size—we have 8,500 employees—is to communicate. The eligibility workers, our frontline troops, must have a clear understanding of the direction of the department and how they fit into it. It's my job to be sure that their morale is high. They must understand the importance of their job, have the tools to do their job, and most important, remember the importance and dignity of the individual client.

IMJ: ***What about frustrations?***

Dir. Coler: One area of frustration is that we have not figured out how we bring people from being dependent into independence, how we get people back into the economy when they've been separated from it for a long time. We haven't figured out how to get people trained and supported and into a job when they've never had a job in their lives and they can't read.

Another area of frustration is teenage pregnancy. It's very difficult to come up with solutions to that dilemma. It goes far beyond our department. Many of the infants born to teenagers will end up on public aid; some will be on public aid for the rest of their lives. It's tragic to see young lives totally altered when they become parents before they have made a positive decision to be parents.

The costs are astronomical. Suffering that occurs as a result is awesome. Many of these babies are born at a low birth weight or with certain afflictions because the mothers have not had proper prenatal and postnatal care. That's a very frustrating area and one I'm concerned about.

IMJ: *What's the budget this year for IDPA?*

Dir. Coler: $3,400,261,900. The Department of Public Aid is one third of the state budget. If you take Education and the Department of Public Aid, you're talking two thirds. It's big.

IMJ: *In the very broadest of terms, where does that money go?*

Dir. Coler: About $1.8 billion goes to Medicaid, and about $1 billion to welfare, $240-270 million to the administrative budget, and $.5 billion to long term care in nursing homes. Those are the major slices. We have smaller amounts—$8 million to refugees for example. Also you have to know that when we talk about the public aid budget we include $100 million a year in food stamps that don't even appear in dollar form.

IMJ: *How would you break out the total proportion that goes to health-related areas?*

Dir. Coler: $1.8 billion—it's over half.

IMJ: *Until several months ago, the department paid up to $500 per hospital stay for General Assistance (GA) patients. That cap was removed through emergency legislation. Can you describe the events which led to the Governor's decision to lift that cap?*

Dir. Coler: The Governor and I had determined that, next to a welfare grant increase, this was the number one priority for the Department of Public Aid. We were able to achieve the welfare increase as result of legislation enacted last spring for our budget. We were able to remove the GA cap in January of this year.

I was very pleased that during my first year, we were able to eliminate two areas that had caused a lot of hardship. The GA cap was causing a lot of problems for a lot of hospitals. A lot of our GA clients did not have the access to medical care they needed. So we were extremely pleased to lift that cap, which had a price tag of about $70 million a year.

IMJ: *The new Illinois Competitive Access and Reimbursement Equity Program (ICARE) has placed hospitals in a competitive position with respect to treatment of public aid patients. Tell us about the program. What percentage of Illinois hospitals do you think will have contracts by the time you're finished?*

Dir. Coler: Probably the great majority of those who worked with the department under the old system.

IMJ: *How is implementation proceeding?*

Dir. Coler: Illinois is the second state in the country to implement competitive contracting. So far it's going very smoothly. The state medical society, hospital association, government, labor, insurance, business, all agreed to this bill. There was no institutional opposition. So we really had a marvelous piece of legislation, with a lot of commitment and involvement. I think it will mean that government will be less involved with better results because the marketplace will control costs instead of government regulation.

IMJ: *Tell us about the Hospital Service Procurement Advisory Board set up under the program. How does it work?*

Dir. Coler: They review all of the contracts we propose to sign with the hospitals. They decide whether or not the contracts are appropriate. If they're not, they will so state to me. I have the option to go ahead and contract with the hospital anyway. If I do that, I must put my reasons in writing. So far we haven't had any disagreements.

IMJ: *We understand that there's a mechanism to determine if a patient should be referred to a tertiary care facility. Can you describe how that will work?*

Dir. Coler: We're going to have a hotline to give medical providers throughout the state access to quick information for pre-approvals. These pre-approvals are needed for specialty care.

IMJ: *Who will determine at what point a patient should be referred? Does the hotline staff make that determination?*

We haven't figured out how to get people trained and supported and into a job when they've never had a job in their lives and they can't read.

Dir. Coler: Either that or they would get it through the same people who currently do our pre-approvals. We haven't had a hotline in the past. We needed pre-approvals for some types of procedures that are high cost or specialty—organ transplants, and some types of surgery.

IMJ: *Let's talk about the doctor's interaction with the department. The physicians really do a lot for the reimbursement that they receive. It's been said that some are reluctant to treat public aid patients because the reimbursement rates are lower and the*

paperwork is a burden and reimbursement takes a long time. Many doctors elect to avoid the complications that are characteristic of that system. As a result, it could be said that public aid patients have limited access to care in some parts of the state. What about access? What's your responsibility in terms of access? Don't you feel it's important to ensure that every patient has access to medical care?

Dir. Coler: Absolutely. That was one reason why we were so anxious to get the $500 cap off. I think it's important for the department to ensure that there is not a two-tiered system of health services in the state—one for those who can afford it, and one for those who can't. Access to good quality health care is something that is extremely important and cost effective to provide.

We have to set up a system in which it is not difficult for physicians to participate. Our involvement with HMOs is one way to approach that.

What we need for poor people is a system of health care that emphasizes prevention and well-being, not one that so typically results in a person with multiple diagnoses visiting an emergency room rather a family physician. HMOs offer us the opportunity to set up a primary care physician for poor people. We currently have contracts with about six HMOs which could potentially provide care for up to 100,000 clients.

We continually discuss how these projects are working out with the Illinois State Medical Society. ISMS has been a lot of help to us in terms of providing advice, not only in this area but in all areas of our provision of medical service.

I think the competitive contracting will make it easier for our clients to get quality care because we will have signed contracts with hospitals to guarantee that inpatient care will be provided. We have it in the contract. It's not something we have to guess about. Our clients will know what hospitals we do business with, because we will be notifying all of them.

There are other types of medical care systems that I think are going to come to the forefront in the future. These will continue to emphasize a system of health care as opposed to providing health care only after someone is sick.

It costs a lot more money, time and effort to get sick people back on their feet than if they had been involved in preventive health care. We continually work with the medical profession to weed out inadequate or inappropriate care. We have a committee of doctors appointed with advice from the Illinois State Medical Society that helps us to do this. Our ICARE program for competitive contracting provides for a contract with a medical organization to screen and monitor care that the clients are receiving. I think that will be one of the keys to the success of the competitive bidding program. We will probably have the same group doing that work as conducts similar screening for the Medicare program in Illinois.

I want to make sure that during the time these people need our help, they get it in such a way that their dignity is not further stripped as a result. It's problem enough when you're poor; you feel bad enough about it.

IMJ: *What about turnaround time in reimbursing physicians for treating public aid patients? We know at one time there was quite an issue over the time lapse between physician's billing and receipt of payment.*

Dir. Coler: I don't think that's happening now. We're paying our bills on time. I think they get paid in three days. There may be a few exceptions here and there, but payment cycles are not a problem. It's very much our responsibility to administer our program so as to eliminate inappropriate fiscal disadvantages to participating in the program.

IMJ: *Are fraud and abuse big problems right now?*

Dir. Coler: Huge. Very large dollars are involved in Medicaid fraud, as you can see from the indictments. You're talking about millions and millions of dollars.

IMJ: *And it brings us back to access again. From what I understand, many doctors are reluctant to deal with the paperwork that's necessary to rule out the fraud and abuse. It slows things down.*

Dir. Coler: Well, there's always more processing involved with provision of care to a public aid client than a private pay patient but I think we're doing an increasingly better job of making sure our bills get paid on time. We are trying to have a system that places less of a burden on the people who are providing the care.

It's our responsibility to police the program and to keep the exploiters out of it because that's one reason why some physicians might not want to become associated with providing service to Medicaid people. In so many instances, medical care has not been provided to clients but they have been treated through ripoff operations that can give the whole enterprise a very distasteful reputation. People don't want to get near a situation where that kind of scandal is going on. We want people to understand that we're doing everything we can to root it out, and we are indeed rooting it out. That will cut down on the



Government can never, in my mind, behave in a dictatorial or reactive way. The responsibility's too important. You have to breathe in and out with the professionals you work with.

number of people who don't want to get involved because they just don't want to be anywhere near those kinds of situations.

Access is a problem for poor people. They all contend that the provision of medical services is designed to exploit them. Medicaid clinics—you've read about the many indictments that the department's been involved in. We assisted the U.S. Attorney in obtaining indictments for those health care practitioners who sought to exploit clients in the system. One investigation resulted in the largest indictment in the history of the state; about 40 doctors were indicted. They were providing a type of pill that gives a heroin like high. They charged Medicaid for prescriptions that were not needed which were then sold for cash as heroin substitutes. We have a responsibility to try and keep our clients from being exploited in that manner.

IMJ: *Tell us about the new recipient I.D. system.*

Dir. Coler: The new recipient I.D. card system is designed to restore some integrity to the basic system used to identify eligible clients participating in any of the IDPA programs—Medicaid, Cash Assistance and food stamps.

The previous card was without any integrity as far as I was concerned. If you knew where to go, you could go out in the street and buy one of them in a couple of hours for between $50 and $100. We had some recipients receiving as many as 20 and 30 replacement cards. I don't believe someone loses their card that many times. It was an extremely easy card to forge—child's play. When we had the press conference announcing it, we made a card right there for the camera. I shook out some 2,000 phony cards we had confiscated. That's a million dollars a month just for those cards. The FBI raided a gambling parlor and found 700 cards and a photo shop where they were manufacturing Illinois drivers licenses and welfare cards.

The new card will not be child's play to replace. It's state of the art. The picture that's on it is not a picture, it's a photo image and it's engraved into the surface of the card by a patented machine that's computer driven. Once that image is engraved in the card, that image is also stored in the computers. So if someone does try to alter it and comes in with a new picture on it, the computer picture is still the same. If the picture in the computer and the picture of the person holding the card don't match, we can call the cops. The fact that people understand that this card is as technologically advanced as anything that is available today deters a lot of people from claiming a card when they don't have one coming. We believe that the whole system will pay for itself within the first three or four months. It cost about $1 million—$3.15 a card—to issue some 350,000 of these. It is an extremely important item in terms of security since it is the basic key to the Illinois welfare system.

IMJ: *We understand that the recipient utilization review program is another anti-fraud measure.*

Dir. Coler: Our greatest tool in fighting Medicaid fraud is the computer. We deal with millions of bills and hundreds of thousands of clients. It's impossible to approach the review of those programs without the aid of the computer. And so that particular program is really a computer program designed to kick out and red flag those recipients who have a utilization rate that goes beyond certain norms. There are some welfare clients who just seem to utilize doctors inappropriately. For whatever reason, they might make 10 visits to a doctor in a week or whatever. And when we find those patterns, we get in touch with that client and correct the situation.

We have a similar program for physicians. If somebody is writing an extremely high number of "scripts" or prescribing a certain procedure at a rate that exceeds the norm by some particular level, the computer search program kicks that out. And then we have investigators to follow that up. So the computer hunts for patterns of fraud, and then our program integrity staff will know where and how to look. We examine the situation and work with the

physician advisory committee to determine the appropriate response to the situation. That can range from suggesting to someone that there is a problem to criminal indictment.

IMJ: *How are the demographics of your client population changing?*

The population is getting a lot older. By the year 2000, one of every six people will be over the age of 65. . . .I have come to appreciate the tremendous importance of thinking about long-term care, given the way our population is changing.

Dir. Coler: The population is getting a lot older. By the year 2000, one of every six people will be over the age of 65. None of us like to think about becoming older. Society doesn't like to think about it. But the role of the senior citizen in our society has changed a lot. Our aging members are not necessarily revered and honored; they are often forgotten and without purpose in their lives.

I have come to appreciate the tremendous importance of thinking about long term care, given the way our population is changing. I've been very concerned and excited about what we're doing with the long-term care industry. The basic supports that people depend on are stripped away from many of them when they retire. It's important for those individuals to be in a home that can help to replace those pillars that so mark the quality of our lives.

I think the long term care industry feels very positively about the kind of leadership that the state is providing. We just had the first Illinois conference on long-term care. It was co-sponsored by all the departments involved in long-term care as well as all the major associations representing the industry—1,100 people. Illinois now has the richest quality incentive program for nursing homes in the country. We'll pay more for the extras that enhance the quality of life in nursing homes. We want to pay for that. If a nursing home qualifies for the whole quality incentive program, it can mean an extra $66,000 a year.

IMJ: *Tell us a little bit more about that quality incentive program.*

Dir. Coler: QUIP stands for quality incentive payments. This applies after you've met the basic standards. The money is $9 million this year and $19 million next year. Homes will be graded in five areas. Patient care is first, and half of the money will go for good care plans.

Second is patient satisfaction. When you go into a restaurant or an airline, they ask, "How did you like our service?" We think that's a good idea in nursing homes. So nursing homes have to ask their residents, "How are we doing, do you like the food, are you happy here, do you feel safe, do you like the activities?"

A third area is involvement with the community. Fourth we look at structural aspects of the home and, finally, the activities. Does the nursing home work hard to get the patients involved with the community, and the community involved with the patients? Do they feel a part of the neighborhood they live in, or are these isolated institutions?

IDPA has hired 115 nurses to be out there managing cases individually. The nurses' jobs should be to know those homes like the backs of their hands. These are not clip board carriers who are to go in there and read some paper records. They will know what is going on in that nursing home. They will plan with the administration what they have to do to qualify for these incentive payments and the qualifying criteria are going to be very clear. We have provided some incentives. We want to have the best nursing homes in the country. And we think it's possible to achieve that.

IMJ: *You're putting focus on quality issues and coming down hard on fraud and abuse. That should help you to persuade more physicians to participate.*

Dir. Coler: And that's another reason why we want to work so hard to have a good, positive, progressive working relationship with groups like the Illinois State Medical Society and Illinois Hospital Association. It can't be a "we" versus "they" type of situation.

Government can never, in my mind, behave in a dictatorial or reactive way. The responsibility's too important. You have to breathe in and out with the professionals you work with. All too often, I think, bureaucracies sometimes assume a disposition of power that is inappropriate because they don't seek to consult and involve people before decisions are made. I value the advice of health professionals who are going to be impacted. If I work with them to define the problems and develop solutions, our responses will be better informed and our administrative decisions will be supported by the medical community. It's much better than those situations where we end up in court.

Suing the Department of Public Aid, was so common in the past. When you have to administer through lawsuits, that's how you do business. The creed of process has really been lost. It takes a lot of time, it costs a lot of money, and people are never well served when that is the end result—regardless of

whose fault it might be. Whenever you have those long drawn out situations, somebody missed the point.

That's one reason why I'm so pleased that that is not the situation now. If you talk to various vendor groups now, I would hope, you'd find that things are more positive. And I think one of the reasons is that they understand the importance I put on the involvement of the various provider professionals. We have a reputation of being open minded while at the same time being strong in our commitment to the policy objectives we talked about here today—serving that individual citizen of the state of Illinois who is very much in need of the services of the Department of Public Aid.

IMJ: *What is your biggest challenge today?*

Dir. Coler: I think our biggest challenge is to find the most efficient way to bring the tremendous resources at our disposal to address the problems of the clients of the Department of Public Aid. It's our job to get them from the situation where they are dependent on welfare back into the situation where they are independent individuals attached to the economy of our society and functioning without the help of government. I want to make sure that during the time these people need our help, they get it in such a way that their dignity is not further stripped as a result. It's problem enough when you're poor; you feel bad enough about it. It shouldn't be demeaning to come in to our department and ask for help that you have a legal right to receive.

So I stress very much in all that we do the importance of the dignity of that individual and the fact that we're going to offer not just a check but a chance. We have to take careful measure to make sure that that single parent or that child or that man who is out of work is not in any way suffering because they're interacting with our department. I think there are a lot of people out there who carry stereotypes in their minds that aren't true, who think that just the fact that a person is poor means that there's something wrong with them. And therefore it's okay for a bureaucracy to heap whatever scorn and ridicule it might perpetrate. I know that certainly is not what the Governor had in mind when he put me in this job. Nor was it what the people of the state of Illinois had in mind when they had the General Assembly propose and pass the laws that I implement. Yet, I think that a lot of people will always believe that, just because people are poor, there is something innately wrong with them.

On the other hand, I think there are an awful lot of people who understand that maybe they're just a paycheck away from being a client of the Department of Public Aid. They could be one job away from being a client of the Department of Public Aid, one child support payment away from being a client of the Department of Public Aid or one medical tragedy away from being a client of the Department of Public Aid. My greatest challenge is to make sure that we can consistently provide help to people in a way that will empower them to get back on their feet.

My greatest challenge is to make sure that we can consistently provide help to people in a way that will empower them to get back on their feet.

The second part of that challenge is to do a good job of communicating to the citizens of this state. They should know what we're doing and why we're doing it and how that mirrors their wishes through the General Assembly. That's another goal the governor gave me when I came here. He wants to make sure that people understand what we're doing with $3.4 billion. So they will support the resources that we need to do that job. That's one of the reasons why we work hard at explaining what we do. I'm working hard at it right now.

IMJ: *How has your perspective on the public aid system changed since you came on the job?*

Dir. Coler: I don't know that it *has* changed a great deal. I was pretty familiar with the department when I came in. I certainly have been excited about the involvement and leadership that the department has provided in changing the basic ways that we procure and manage medical care for the department's clients.



We have made radical changes in the way we're providing medical care. We're making radical changes in the way we provide assistance to the long term care industry; radical changes in our focus on the subject of child support.

We're revolutionizing the basic way we do our work. We're going to throw away the eligibility workers' pencils and the green eye shades. Right now, 6,000 of them fill out 50-60 forms for every case they open; they reenter the name 60

times on those forms. We're going to put a computer on the caseworker's desk. We've just announced an $8.5 million procurement of some 22 super minicomputers and some 2,000 terminals. And that whole process is going to be automated much like when Henry Ford developed the production line. We will eliminate 10 million government forms over the next two years. We're also hoping to cut by half the amount of time it takes for somebody to come in and get qualified for aid. The new card system will do a lot to ensure that we can keep cheaters' hands out of the taxpayers' pockets and take good care of the people who have the aid coming.

And the next item we'll be working on is very difficult: how do we get people jobs who don't have them, and whose skills put them into the very bottom of the labor market. That's the real challenge in this department. "Not just a check, but a chance" is not just a slogan around here. It's a call to action and a call to creativity and a call to not only the employees of this department, but all the social services in the state to say, "Hey, what have we done today that could help somebody get a job so they don't need us anymore?"

So much of our social services work involve's analyzing the problems of the poor or the problems of the family where there is abuse going on. One characteristic you find common to all these high problem families is that they don't have a stable income. We need to put a lot more energy and time into figuring out how we can get people back into our society's economic mainstream when they have been absent for so long.

IMJ: ***And back into the mainstream of medical care delivery?***

Dir. Coler: That's right. If people are sick, they can't work, can they? The one thing that's characteristic about clients when they come into those emergency rooms is that they're very, very sick. Why are they so sick when they get there? Because they don't have a primary physician, because they have no access to health care.

Access, as you said earlier, is a problem. That's why everybody is so excited about the work that we're doing with the Illinois State Medical Society. We are working to do a better job of providing health care, especially preventive health care, for these families.

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MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Reactive hyperglycemia was evaluated in 72 patients with acute onset of stroke. Its short term survival was analyzed. The mortality rate was 78% in non-diabetic patients with hyperglycemia, 45% in diabetic patients, and 29% in normoglycemic nondiabetic cases. This hyperglycemia may indicate a stress response, pre-existing hyperglycemia, or systemic complications. In the nondiabetic patients, the glucose level correlated with the neurologic status of motor power, muscle tone, sensation, visual fields, head and eye deviations and consciousness. (Candelise L. *et al.; Arch Neurol* 42#7:661-3, July 1985)

Forty-seven patients with chronic progressive multiple sclerosis received CT scans and neuropsychological tests for memory and verbal intelligence. The performance on these neuropsychological tests correlated inversely with the size of the ventricles, particularly the width of the third ventricle. The duration of the illness and severity of the disabilities were not related to these intelligence tests. The CT scan was shown not to be an effective method of evaluating the number of sizes of plaques in the brain but magnetic resonance imaging shows promise of more effectively identifying white matter demyelination of the cerebrum. (Rao, S., *et al.; Arch Neurol* 42#7:678-82, July 1985)

A double blind randomized placebo controlled trial of antihypertensive treatment was conducted on 840 patients over the age of 60 between 1972-84. The total death rate was 70/1000 patient years in the placebo group and 52/1000 in the treated group. The mortality due to cardiovascular disease was significantly reduced, but insignificant due to cerebrovascular disease in the treated group. Only 35% of the initial group of patients continued on this program until 1984; 36% left the study prematurely, 19% died, 5% had a terminating non-morbid episode, and 4% had a terminating morbid cardiovascular event. (Amery, A. *et al.; The Lancet* 8442#1:1349-55, June 15, 1985)

Early surgery on 212 newborns with myelodysplasia effected an increase in survival on these patients when combined with new technical and social approaches. Presence of triploidy, hydroencephaly, fatal cardiac and renal malformations, the degree of paralysis and orthopedic deformities, the presence of central nervous system infections and bleeding will alter the therapeutic approach. (McLaughlin, J., *et al: N Engl J Med* 312#25:1589-94, June 20, 1985)

The xenon 133 inhalation method was used for measuring the cerebral blood flow in three categories of aged patients. Two hundred sixty eight neurologically normal patients were compared as to cerebral perfusion in non-smokers, smokers, and those who stopped smoking. Nonsmokers showed the highest perfusion. Smokers who quit showed improved perfusions within one year despite a history of smoking for 3-4 decades. (Rogers, R. *et al: JAMA* 253#20:2970-4, May 24/31, 1985)

New infections with tuberculosis is an important risk factor for patients admitted to nursing homes. Only 12% of newly admitted residents to nursing homes showed reactivity to the tuberculin skin test. Those who were not reactive initially had a 5% rate of conversion for each year spent in a home with a known recent infectious case, and a 3.5% rate for each year in a home with no recognized recent case. (Stead, W. *et al: N Engl J Med* 312#23:1483-7, June 6, 1985)

The authors suggest the use of a quantitative assay of fecal blood that measures the fluorescence of the heme derived porphyrin. In 98% of healthy volunteers the fecal hemoglobin was less than 2 mgm/gram of stool. In patients with GI symptoms but negative GI workups the fecal hemoglobin were slightly higher, particularly with ingestion of meats and aspirins. The fecal hemoglobin concentrations were higher in patients with GI cancer. The sensitivity of porphyrin test as contrasted to the guaiac test may be in the more proximal gastrointestinal lesions where degradation of the blood has commenced. (Ahlquist, D., *et al: N Engl J Med* 312#22:1422-7, May 30, 1985) ◀

EKG

(Continued from page 74)

Answers: 1. B. C. E. 2. A. C.

The twelve lead ECG shows a slow rhythm with normal QRS duration at a rate of 45 beats per minute without P waves. This is an AV junctional rhythm. The absence of P waves implies sinus node dysfunction or sinoatrial block or sinus arrest. The atria and the ventricles are dissociated; AV dissociation. In lead II, the black bar marks a premature beat. This black bar marks a P wave suggesting it is a supraventricular or sinus capture beat. This atrial capture beat conducts to the ventricles with a QRS morphology that is slightly different from the junctional beats. Other ECG's in sinus rhythm would be required to determine which QRS morphology has aberrant intraventricular conduction, the atrial capture or the junctional beats.

This arrhythmia developed in a patient with chest discomfort and hypotension. His history prior to this was unstable angina. Now an acute myocardial infarction would have to be considered. It was ruled out by enzymes and a thallium myocardial scan since he had known normal ventricular function initially. More antianginal medication now could possibly worsen his hypotension. Intravenous atropine and dopamine were successful in raising his blood pressure to 130/70mmHg and a sinus rhythm returned. In this setting, atropine could be considered controversial since it could result in a tachycardia and aggravate the angina. In our patient, it had no effect at all. Dopamine increased the blood pressure and presumably the coronary perfusion pressure. Angina was relieved and sinus rhythm was restored. If this had failed, temporary pacing would have been considered. The patient subsequently underwent quadruple aorta coronary bypass surgery and did well. ◀

$100,000 + guarantee, plus other incentives, for approved physicians in the following specialties in Mid-Michigan community—

Obstetrician-gynecologist, orthopedic surgeon, general surgeon, ENT, urologist, family practitioners, pediatrician and internists.

Contact: Vice President of Professional Services
(517)723-5211, Ext. 1823

PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

BLOOMINGTON:
Internal Medicine—To join an active six member IM practice in mid-western university community. A sub-specialty in Rheumatology, Endocrinology, or Allergy is desirable, but not necessary. Contact: J. Buchanan, The Health Center, 702 N. East St., Bloomington 61701 (309) 827-5051. (9)

BRADFORD:
Family physician wanted to take over 32 years of well established rural practice with office and house—reason retirement. 120 bed equipped hospital 20 minutes drive, 35 miles from major medical and educational center. Elementary and high school 2 blocks from home. Contact (309) 897-8181. (6)

CARBONDALE:
Multi-specialty group needs the following physicians—Allergist, pulmonologist, otolaryngologist and orthopedist. Contact: Wayne Given, 2601 West Main Street, Carbondale 62901, (618) 549-5361. (12)

DES MOINES, IOWA:
Obstetrician and Gynecological Physician—Planned Parenthood of Mid-Iowa. A reproductive health care agency serving 17,000 patients. New medical center, exciting progressive agency, a leader in the state. Des Moines is a progressive city with a totally revitalized downtown area. Contact Dan Topp, Executive Director, P.O. Box 4557, Des Moines, Iowa 50306, (515) 280-7000.

FAIRFIELD:
Lucrative family practice in southern Illinois available, including office building, all equipment (x-ray, electrocardiogram, diathermy, three Birthcher's, lab). Can accommodate two to three physicians. More information can be obtained by calling (618) 842-2187. (6)

GLEN ELLYN:
Full or Part-Time Radiologist—Position in 60-physician, multispecialty, outpatient facility for radiologist. Facilities include flouroscopy, tomography, mammography, diagnostic ultrasound, plus general radiology. Salaried position with excellent fringes, excellent workload and hours in comparison with hospital setting, plus the ability to work with a quality leading group in a pleasant suburban environment. Send CV to: Glen Ellyn Clinic, 454 Pennsylvania Avenue, Glen Ellyn 60137.

KANE COUNTY:
Experienced occupational health physician needed to direct medical program in manufacturing plant in Southwest Suburbs. Call regional medical director (312) 981-2195. (4)

MONMOUTH:
Internist or family practitioner to join a practice in a small town. Terms negotiable. Please send curriculum to P.O. Box 183, Monmouth 61462. (12)

ROCK ISLAND:
Internist group looking for a fourth physician to join growing area of Illinois Quad Cities. General internist and/or internist with sub-specialty willing to practice some general internal medicine. Offering financial guarantees and free rent for first year. Contact: Greg Romans, 2701 17th Street, Rock Island, IL 61201. (3)

SAYBROOK:
Family practitioner—Excellent opportunity in east central Illinois; large modern office available; rural setting near modern, well-equipped community hospital; community is within twenty minutes of major universities, tertiary care centers; metropolitan area with major shopping, recreational and cultural activities available; financial incentives possible. Contact William Stack (309) 475-3521. (3)

VANDALIA:
Specialists wanted. Family practice, internal medicine, pediatrics, general surgery, ENT, orthopedic surgery. One year guarantee with free office space. Needed for 92-bed acute, 134-bed LTC hospital in southern Illinois. Market covers 25,000+ people. Single office or clinic setting possible. Contact: Darrell Pile, Adm., Fayette Co. Hospital, Taylor Street, Vandalia, 62471 (618) 283-1231. (3)

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

SEPTEMBER

Emergency Care

Advanced Trauma Life Support Provider Course
For: Physicians, Emergency Personnel, Nurses, Course, September 11-12, 8:00 A.M.-5:00 P.M., Springfield. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $350. **Reg. Limit:** 20. **Credit:** Category 1: 16 hours. **Contact:** Charles E. Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** (217) 782-7711.

Geriatrics

Geriatrics
For: Physicians, other medical professionals. Symposium, September 14, 1:00-5:00 P.M. Lawrenceville, IL. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25.00. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Charles E. Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** (217) 782-7711.

Gynecology

Premenstrual Tension Syndrome
For: Physicians, other health professionals. Symposium, September 26, 1:00-5:20 P.M., DuQuoin, IL. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25.00. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Charles E. Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** (217) 782-7711.

Plastic Surgery

Plastic Surgery Nurses' Conference
For: Nurses, other health professionals. Conference, September 27, Springfield, IL. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25.00. **Reg. Limit:** None. **Credit:** 4 CEU's. **Contact:** Charles E. Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** (217) 782-7711.

Internal Medicine

Postgraduate Conference in Internal Medicine
For: Physicians. Symposium, September 26-27, 8:00 A.M.-5:00 P.M., Iowa City. **Sponsor:** University of Iowa College of Medicine, Continuing Medical Education, 285 Med Labs., Iowa City, IA 52242. **Fee:** $200. **Reg. Limit:** None. **Credit:** Category 1: 13 hours. **Contact:** R.M. Caplan, M.D. **Phone:** (319) 353-5763.

Rheumatology

Medical and Surgical Management of Arthritis
For: Practicing physicians. Seminar, September 13-20, St. Louis. **Sponsor:** Washington University School of Medicine, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $400. **Reg. Limit:** 50. Reg. Deadline: August 13. **Credit:** Category 1: 20 hours, AOA: 20 hours, AAFP Prescribed: 20 hours. **Contact:** Loretta Giacoletto, Administrative Coordinator. **Phone:** (800) 325-9862.

Infectious Disease

Infectious Disease Update
For: Physicians, other medical professionals. Symposium, September 12, 3:00-7:00 P.M. Quincy, IL. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25.00. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Charles E. Osborne, Ed.D., Assistant Dean for Continuing Medical Education. **Phone:** (217) 782-7711.

Cardiology/Nuclear Medicine/Radiology

10th Annual Nuclear Cardiology Symposium
For: Physicians in cardiology, radiology, and nuclear medicine. Symposium, September 18-20, Milwaukee, WI. **Co-Sponsors:** Cardiovascular Disease Program, Milwaukee Clinical Campus, School of Medicine, University of Wisconsin, 465B WARF Bldg.; 610 Walnut St., Madison, WI 53705. **Fee:** To Be Determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 20 hours; University of Wisconsin CEU's; voice credit—approx. 20 hours. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** (608) 263-2856.

Cardiology

Cardiothoracic/Laser
For: Physicians, nurses, medical students, and related paramedicals. Seminar, September 9, 5:30-6:30 p.m. **Place:** Northwestern University Medical School Alumni Center, 303 E. Chicago Ave. **Sponsor:** Northwestern Memorial Hospital Laser Committee. **Fee:** None. **Reg. Limit:** None. **Credit:** None. **Contact:** Elaine Brown. **Phone:** (312) 908-4480.

Neurology

Current Clinical Neurology: A Comprehensive Review
For: Neurologists, Psychiatrists & Neurosurgeons. Lecture, September 9-13. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $540. **Reg. Limit:** 90. **Credit:** Category I: 40 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800)621-4649 in Illinois; (800)621-4651 outside Illinois.

Psychiatry

Sexual Medicine
For: Psychiatrists General Family Practitoners. Lecture, September 11-13. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $335. **Reg. Limit:** 90. **Credit:** Category 1: 24 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Dermatology

Specialty Review in Dermatology
For: Dermatologists. Lecture, September 16-20. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $550. **Reg. Limit:** 90. **Credit:** Category 1: 34 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Plastic Surgery

Plastic Surgery Nurses' Conference
For: Nurses, other health professionals. Conference, September 27, Springfield, IL. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25. **Reg. Limit:** None. **Credit:** 4 CEU's. **Contact:** Charles E. Osborne, Ed.D., Assistant Dean for CME. **Phone:** (217) 782-7711.

Otolaryngology

Otolaryngology Head and Neck Laser Workshop
For: Otolaryngologists, D.O.'s and D.O.V.'s. Workshop, September 8-10, Chicago. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $1,000. **Reg. Limit:** 15. **Credit:** Category 1: 20 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Radiology/Obstetrics & Gynecology

5th Annual Breast Imaging Conference
For: Radiologists, Radiologic Technologists and others interested in breast imaging. September 22-24, St. Petersburg Beach, FL. **Co-sponsors:** University of Wisconsin—Dept. of Surgery & The Ausonics Corporation, New Berlin, WI. **Fee:** To Be Determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 18 hours, University of Wisconsin CEU's: Approx. 18 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Internal Medicine

Specialty Review in Endocrinology & Metabolism
For: Internists and Endocrinologists. Lecture, September 20-October 4. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $615. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649 in Illinois. Outside Illinois: (800) 621-4651.

Postgraduate Conference in Internal Medicine
For: Physicians. Symposium, September 26-27, 8:00 A.M.—5:00 P.M., Iowa City. **Sponsor:** University of Iowa College of Medicine, CME, 285 Med Labs, Iowa City, IA 52242. **Fee:** $200 **Reg. Limit:** None. **Credit:** Category 1: 13 hours.

Internal Medicine/Oncology

Specialty Review in Medical Oncology
For: Internists and Oncologists. Lecture, September 30-October 4. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $615. **Reg. Limit:** 90. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

General Practice/Family Practice

Folk Medicine and Refugees
For: Physicians, nurses, and other health professionals. Conference: September 26, Madison, Wisconsin. Co-sponsors: University of Wisconsin Extension-CME and Wisconsin Dept. of Health and Social Services, 465 WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** To Be Determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 6 hours, AAFP Prescribed: Approx. 6 hours, and University of Wisconsin CEU's: Approx. 6 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Rheumatology

Medical and Surgical Management of Arthritis
For: Practicing Physicians. Seminar, September 13-20, St. Louis. **Sponsor:** Washington University School of Medicine, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $400. **Reg. Limit:** 50. Reg. Deadline: August 13. **Credit:** Category 1: 20 hours; AOA: 20 hours; AAFP Prescribed: 20 hours. **Contact:** Loretta Giacoletto, Administrative Coordinator. **Phone:** (800) 325-9862.

Neurology/Family Practice/Internal Medicine

Multiple Sclerosis Conference
For: Physicians in neurology, family practice and internal medicine. Symposium, September 20-21, Madison, WI. **Sponsors:** University of Wisconsin-Extension; Continuing Medical Education and Department of Neurology, School of Medicine, University of Wisconsin. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 10 hours; AOA: Approx. 10 hours; AAFP Prescribed: Pending. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Cardiology/Emergency Medicine/Geriatrics/General Practice

Coronary Care Update'85

For: Physicians and nurses in cardiology, emergency medicine, geriatrics and general practice. Symposium, September 20-21, Madison, WI. **Co-sponsors:** University of Wisconsin-Extension; Continuing Medical Education and School of Medicine, University of Wisconsin, 465B WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 10 hours; AAFP Prescribed: Pending, and University of Wisconsin CEU's. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Surgery/Family Medicine

Lake County Medical/Surgical Seminar

For: Physicians. Symposium, September 18, 8:30 A.M.—12:30 P.M., Waugekan, IL. **Sponsors:** St. Therese Hospital, 2615 Washington Street, Waukegan, IL 60085, and Merck, Sharp & Dohme; Du Pont and Lilly. **Fee:** $10. **Reg. Limit:** None. **Credit:** Category 1: 4 hours; AAFP Prescribed: 4 Hours. **Contact:** R.M. Adelman, D.D.S., M.D. **Phone:** (312) 578-2555.

OCTOBER

Cardiology

Practical Aspects of Vascular Disease

For: Physicians and other health professionals. Conference, October 4, Madison, Wisconsin. **Sponsor:** University of Wisconsin Medical School Departments of Family Medicine, Radiology and Surgery, 465 WARF Bldg., 610 Walnut, Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 7 hours; AOA Category 2-D, and University of Wisconsin CEU's: 7 hours. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** (608) 263-2856.

Echocardiography

For: Cardiologists, Echocardiographers, Field technical specialists. Course and Workshop, October 22-25, Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60610. **Fee:** $350. **Reg. Limit:** 250. **Credit:** Category 1: 26 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Neurology

Clinical Neuroimmunology Conference

For: Neurologists. Course, October 31-November 2. **Sponsor:** The University of Chicago, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** AMA Category 1: To be determined. **Contact:** Marlene Goldberg, Conference Mgr. **Phone:** (312) 962-1056.

Psychiatry

The Psychiatric Interview

For: Psychiatrists. Course, October 18-20. **Sponsor:** The University of Chicago, 5841 Maryland, Box 139, Chicago, IL 60637. **Place:** Chicago Hilton and Towers. **Fee:** $375. **Reg. Limit:** None. **Credit:** AMA Category 1: 17 hours. **Contact:** Marlene Goldberg, Conference Mgr. **Phone:** (312) 962-1056.

Psychiatry/Pediatrics/Nutrition

Eating Disorders

For: Physicians and other health professionals. Conference, October 11-12. **Sponsor:** University of Wisconsin Department of Pediatrics; Eating Disorder Clinic-University of Wisconsin, 465 WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: To be determined; ADA: Pending; AOA Category 2-D; WNA Pending; and University of Wisconsin CEU's. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Critical Care

Fourth Annual Chicago Critical Care Symposium

For: Physicians and nurses and other health professionals. Lectures, Tutorials, October 10-13 at Chicago Marriott Hotel. **Sponsor:** The Chicago Medical School, University of Health Sciences, 3333 Green Bay Rd., North Chicago, IL 60064. **Fee:** Physicians: $375.; residents and allied health professionals: $250. **Reg. Limit:** None. Reg. Deadline: October 8. **Credit:** AAFP Prescribed: 24 hours; Category 1: 24 hours; ACCN: 24 hours pending approval; ACEP: 24 hours pending approval; AARP: 24 hours pending approval. **Contact:** Sybil Michaels. **Phone:** (312) 578-3292.

Otolaryngology

Otolaryngology Head and Neck Laser Workshop

For: Otolaryngologists, D.O.'s and D.O.V.'s. Workshop, October 6-8. **Sponsor:** Northwestern University Medical School, 301 East Chicago Avenue, Chicago, IL 60611. **Fee:** $1,000. **Reg. Limit:** 15. **Credit:** Category 1: 20 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Nutrition/Oncology/General Practice

Frontiers of Nutrition and Cancer

For: Physicians and other health care professionals. Symposium, October 17-18. **Sponsors:** University of Wisconsin CME; Wisconsin Nutrition Council; Dept. of Nutritional Sciences, University of Wisconsin, Madison; Clinical Nutrition Center, University of Wisconsin-Madison; Medical College of Wisconsin, Milwaukee; American Cancer Society; and Wisconsin Dietetic Association. Address: 465B WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 11 hours; University of Wisconsin CEU's and AOA's: Approx. 11 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Internal Medicine & Family Practice

Midwestern Conference on Health Care in the Elderly

For: Physicians, nurses, social workers, and nursing home administrators. Symposium, October 18-19; 8:00 a.m.—5:00 p.m. **Sponsor:** University of Iowa College of Medicine, Continuing Medical Education, 285 Med Labs, Iowa City, IA 52242. **Fee:** $150/M.D.'s, $75/allied health. **Reg. Limit:** None. **Credit:** Category 1: approx. 10 hours; nursing credit; nursing home administrator CEU's. **Contact:** R.M. Caplan, M.D. **Phone:** (319) 353-5763.

Rheumatology

Focus on Rheumatology-1985

For: Physicians and other health professionals. Conference, October 18-19. **Sponsor:** University of Wisconsin, CME and Department of Medicine, 465B WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 9 hours; AAFP Prescribed 8½ hours; AOA Category 2-D: 8½ hours; and University of Wisconsin CEU's: 9 hours.

Obstetrics/Gynecology

Blue Ribbon Baby: Quality Care from Conception to Birth

For: Ob/Gyn M.D.'s, RN's and Midwives. Lecture/Workshop, October 3-4, 8:00 A.M.—5:00 P.M., Oak Brook. **Sponsor:** Rush University, Continuing Medical Education, 600 S. Paulina, Chicago, IL 60612. **Fee:** None. **Credit:** Category 1: 12 hours; ACOG applied for. **Contact:** Barbara Trejo. **Phone:** (312) 942-7119.

Endocrinology

Endocrinology Conference

For: Physicians and other medical professionals. October 10, 1:00 p.m.-5:30 p.m., Lincoln, IL. **Sponsor:** Southern Illinois University School of Medicine. **Fee:** $25. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean for CME. **Phone:** (217) 782-7711.

Neurology/OB-GYN/Psychiatry/Plastic Surgery

China Explorers Cruise Medical Seminar at Sea

For: Physicians and other health care professionals. October 8-21. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $600. **Reg. Limit:** None. **Credit:** Category 1 and AAFP Prescribed: 60 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean for CME. **Phone:** (217) 782-7711.

Cardiology

Doppler and Two Dimensional Echocardiography Workshop: New Advances in Pulsed, Continuous Color Doppler. **For:** Physicians and echocardiography technicians. Lectures and Workshops, October 22-25, 8:30-4:30, Chicago, IL. **Sponsor:** Northwestern University Medical School, 250 E. Superior (Wesley-586), Chicago, IL 60611. **Fee:** $350. **Reg. Limit:** 180. **Reg. Deadline:** October 4. **Credit:** Category 1: 26 hours. **Contact:** Sharon Baruch. **Phone:** (312) 908-4687.

Surgery

Specialty Review in General Surgery, Part 1

For: general and specialized surgeons. Lecture, October 21-November 1, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $840. **Reg. Limit:** None. **Credit:** Category 1: 97 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Cardiology/Surgery/Family Practice

Practical Aspects of Vascular Disease

For: Physicians and other health professionals. Conference, October 4, Madison, WI. **Sponsors:** University of Wisconsin-CME and Department of Family Medicine, 465 WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 7 hours; AAFP Elective: 7 hours; AOA Category 2-D and University of Wisconsin CEU's: 7 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Internal Medicine

Specialty Review in Cardiovascular Disease

Internists, cardiovascular specialists. Lecture, October 7-11, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Fee:** $615. **Reg. Limit:** None. **Credit:** Category 1: 40 hrs. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Specialty Review in Gastroenterology

For: Internists and gastroenterologists. Lecture, October 14-18, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Fee:** $615. **Reg. Limit:** None. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Surgery

Specialty Review in Pediatric Surgery

For: Surgeons. Lecture, October 9-12, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $530. **Reg. Limit:** 90. **Credit:** Category 1: 35 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Advanced Peripheral Vascular Surgery

For: Peripheral vascular surgeons. Lecture, October 7-11, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Fee:** $530. **Reg. Limit:** 90. **Credit:** Category 1: 32 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Pathology

Anatomic Pathology: A Comprehensive Review and Update

For: Pathologists. Lecture, October 12-16, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Fee:** $550. **Reg. Limit:** 90. **Credit:** Category 1: 44 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Clinical Pathology: A Comprehensive Review and Update

For: Pathologists. Lecture, October 17-20, Chicago. **Sponsor:** Cook County Graudate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Fee:** $550. **Reg. Limit:** 90. **Credit:** Category 1: 37 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Family Medicine

Current Cardiology

For: Family and general practitioners, internists. Lecture, October 28-31, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Fee:** $395. **Reg. Limit:** 90. **Credit:** Category 1: 27 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Obstetrics/Gynecology

Specialty Review in Obstetrics and Gynecology

For: Obstetricians and gynecologists. Lecture, October 28-November 2, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Fee:** $660. **Reg. Limit:** 90. **Credit:** Category 1: 55 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Gynecology: Laser Medicine and Surgery at Northwestern Memorial Hospital

For: Physicians, medical students, nurses and related paramedicals. Seminar, October 14, 5-6:30 P.M., Alumni Center, Northwestern University Medical School. **Sponsor:** Northwestern Memorial Hospital Laser Committee. **Fee:** None. **Contact:** Elaine Brown. **Phone:** (312) 908-4480.

Internal Medicine/Family Medicine/Emergency Medicine

Respiratory Critical Care Conference

For: Physicians, nurses, respiratory therapists, and other health care professionals. Conference, October 31-November 1, Madison. **Sponsor:** University of Wisconsin-CME and Department of Medicine, 465 WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** To be determined. **Credit:** Category 1: Approx. 12 hours; University of Wisconsin CEU's: approx. 12 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Dermatology

Advances in Therapy in Dermatology

For: dermatologists, general internists, and allergists. Lectures, October 18-November 1. China and Hong Kong trip. **Fee:** $300. **Reg. Deadline:** September. **Sponsor:** Northwestern University Medical School Department of Dermatology and the University of California. **Contact:** Henry 'Roenigk, Jr., M.D. **Phone:** (312) 649-8173.

Thirteenth Annual Congress on CME Conducted Simultaneously with Annual ACCME /State Conference

Introducing the Total Educational Opportunity

Staff Physicians—DME's—Allied Health Professionals—Educators

Join your colleagues at the Annual Congress on CME to increase your knowledge of the opportunities available to the individual physician to enhance self-directed CME. The Annual Illinois Congress on CME will be conducted on Friday and Saturday, October 11-12, 1985 at the Arlington Park Hilton, Arlington Heights, Illinois.

Keynote Speakers:	Robert K. Richards, Ph.D. Executive Vice-President of the Grand Rapids Area Medical Education Center, Grand Rapids, Michigan Alan B. Knox, Ph.D., Professor of Continuing and Vocational Education, University of Wisconsin, Madison, Wisconsin
Will Focus Their Discussion on the Congress Theme:	"Self-Directed Learning—The Gold Standard"
The Twenty-Three Participative Workshops Will:	☐ Complement your understanding of individualized learning theory for the adult learner. ☐ Identify various means of applying traditional techniques/methodology to self-directed learning. ☐ Provide the opportunity for interaction with physicians who have experienced the individualized approach to CME.
CME Credit:	Nine hours, Category 1 AMA/PRA
Congress Registration Deadline:	September 30, 1985

This year invitations will be extended to representatives from all state medical societies to meet for the Fifth Annual Accreditation Council on Continuing Medical Education/State Conference. The program will convene on Thursday, October 10, 1985 at the Arlington Park Hilton, Arlington Heights, Illinois. The program will consist of small group discussions and cover three major topics of current interest:

CRR Process
The effectiveness of the revised essentials at the state level
CME in an era of cost containment

For additional Congress information, please contact the ICCME, Twenty North Michigan, Suite 700, Chicago, IL, 60602 or (312) 236-6110, Ext. 1181.

ACCME information can be obtained by contacting P.O. Box 245, Lake Bluff, IL 60044 or (312) 295-1490.

CLASSIFIED ADVERTISING

Classified Advertising Rates

	30 words or less	30 to 50 words	50 to 80 words	80 to 100 words
1 insertion	$ 6.00	$ 9.00	$14.00	$20.00
3 insertions	13.00	15.00	28.50	41.50
6 insertions	20.00	26.50	46.00	66.00
12 insertions	33.00	44.00	77.00	110.00

All proposed advertisements should be received by the first of the month preceding publication. A surcharge of $2 will be assessed when a box number is requested.

POSITIONS AND PRACTICE

EMERGENCY MEDICINE—Illinois and Missouri. Full and part time positions available in emergency departments and clinics for qualified physicians seeking lucrative employment opportunities. Outstanding remuneration and comprehensive malpractice insurance provided. For further information contact Amy Eisenman, Staffing Specialist. National Emergency Services, Inc., 1 Hollow Lane, Suite 304, Lake Success, New York 11042 or call (800) 645-4848.

U.S. AIR FORCE MEDICAL CORPS currently is accepting applications for physicians in the following specialties: Surgery (all specialties), Obstetrics/Gynecology, Otorhinolaryngology, Anesthesiology, Psychiatry, Orthopedic Surgery, Cardiology, Allergist, Family Practice, and Internal Medicine. For further information call collect: 1st Lt. Michael V. Vivoda: (312) 263-1207.

PHYSICIAN OPPORTUNITIES—Current openings for physicians of all specialities in the Illinois area and nationwide. Opportunities in solo, hospital and clinic based positions. For further information please contact Physician Recruiters Inc. at (312) 433-7180. All inquiries will be handled on a confidential basis.

MEDICAL PRACTICE FOR SALE in South Chicago area with all equipment and furniture. Grossing over $100,000. Pharmacy on premises. Reasonable terms. Call 312-339-7700 between 2 pm and 6 pm.

SOUTHERN ILLINOIS Family Practice for sale. Town of 12,000, fifteen miles from St. Louis, Missouri. Gross income 1983-$360,000.00 with no OB or Major Surgery. Office 5 blocks from major shopping center and 5 miles from nearest hospitals of 800 beds. Foreign medical graduates are welcome. Reply to Box #1131, c/o the *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

ORTHOPEDIC SURGEON, board eligible or board certified wanted for established group practice in Chicago suburbs, excellent growth opportunity, generous compensation and benefits. Reply to Box #1168, c/o the *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

SOUTHERN CALIFORNIA. Prestigious HMO is seeking experienced specialists and general practitioners for our facilities in Los Angeles and Orange counties. Located in close proximity to major teaching centers, we offer the opportunity for continued professional development and rewarding clinical practice. Excellent compensation and benefits including paid malpractice, life, disability, medical and dental coverage, paid vacations, sick leave, educational leave and retirement plan. Please send C.V. to: Director/ Physician Recruitment, CIGNA Healthplans of California, 700 N. Brand Blvd., Suite 500-24, Glendale, CA 91203.

FAMILY PRACTITIONER. Marshfield Clinic Department of Family Medicine is seeking a BE/BC family practitioner for a new position. The physician joining the Clinic's expanding 5 member department will enjoy the support of one of the nation's largest multispecialty groups, share the philosophy of family-oriented care with a preventive focus, and enjoy full hospital privileges but without the distractions of OB or surgical responsibilities. Marshfield Clinic offers an excellent salary plus extensive fringe benefits. Send C.V. and the names of several references to: E. Grady Mills, M.D., Family Medicine Department Chairman; Marshfield Clinic, Marshfield, WI 54449, or call collect (715) 387-5168.

FAMILY PRACTITIONER/INTERNAL MEDICINE—To locate in Rosiclare, Illinois. 48 bed acute JCAH care facility located on the Ohio River in the beautiful foothills of Shawnee National Forest. Each physician is provided his/her own five room clinic adjacent to the hospital. Contact Roby Williams, Administrator, PO Box 467, Rosiclare, IL 62982. (618) 285-6634.

HOLISTIC DOCTOR. Compensation $25-30 per hour plus percentage. Solo practice. All equipment, personnel furnished. No start up fees. Excellent growth potential. Send C.V. & recent photo to: MLG Health Care Corporation, 1100 Wilmington Ave., Dayton, Ohio 45420.

ARIZONA BASED PHYSICIAN RECRUITMENT firm has opportunities coast to coast. "Professionals working with Professionals." Over 13 years experience. Call (602)-795-7474; or send CV to: Mitchell & Associates, Inc., 2761 N. Country Club Rd., Suite 202, Tucson, AZ 85716.

PHYSICIANS, LICENSED in Illinois, needed to do mobile insurance exams in the north and northwest suburbs. Call (312) 827-9777.

INTERNIST—General internal medicine and geriatric medicine. Active general medical and surgical facility affiliated with University of Illinois at Champaign-Urbana, 35 miles distant. Federal fringe benefits include insurances, retirement/social security, vacation and sick leave, malpractice protection. $55,800-$80,300 range commensurate with background. License any state. English language proficiency required. Equal Opportunity Employer. Call or write W. L. Kannapel, M.D., Chief of Staff, VA Medical Center, 1900 E. Main St., Danville, IL 61832, (217)442-8000 × 563.

VERSATILE SURGEON wanted to complement aggressive family practice group in rural northeastern Minnesota resort community. Well-equipped 40-bed hospital with proven surgical practice volume. Outstanding outdoor recreational opportunities with time off to enjoy it. Reply with CV to E. Johnson, Ely Medical Center, Ltd., 224 East Chapman Street, Ely, MN 55731. Telephone: (218)365-3151.

RETIRING CENTRAL ILLINOIS ORTHOPAEDIST desires board certified or board eligible orthopaedist to take over large general practice. Office completely furnished, x-ray, etc. Only expenditure would be for x-ray and office furnishings. Will introduce to refer-

ring physicians. (309)343-4177.

STUDENT HEALTH. Opening for primary care internist, family physician or pediatrician. Full-time 10 or 11-month position. Competitive salary and benefit package, 40-hour work week. Illinois license, board eligibility/certification, and interest in some gynecology required. Contact: Paul Nelson, MD, Student Health Service, Illinois State University, Normal, Illinois 61761, (309) 438-8655. Search will continue until position is filled. Preference will be given to those applying by Sept. 1, 1985. An Affirmative Action/Equal Opportunity Employer.

PSYCHIATRIST—Full-time adult staff position in well-established HMO serving over 210,000 people in one of the leading metropolitan areas of the Midwest. Join excellent staff of 35 psychotherapists and seven psychiatrists. Outstanding benefits, competitive salaries and a flexible work week providing time for teaching and other professional pursuits. Send curriculum vitae to: Paul J. Brat, M.D., Medical Director, Group Health, Inc., 2829 University Avenue Southeast, Minneapolis, Minnesota 55414.

OPHTHALMOLOGIST, ILLINOIS: Long established general ophthalmology practice available 80 miles SW of Chicago (1½ hrs.). Good family location, excellent hospitals, high surgical volume, professional satisfaction, patient appreciation. New facility ready Fall 1985. Owner will help phase in. Reply to: Box #1152, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

NORTHWESTERN IL. (Near Freeport) General Practice available. Practice grossing $250,000+, seeing 25-30 patients daily. Asking $230,000 for practice, equipment and real estate. Professional Practice Sales, 540 Frontage Rd., Northfield, IL. 60093, (312)441-6111.

OPHTHALMOLOGIST—Exciting opening with group located 45 min. from Chicago. Group well established and has many resources: excellent physicians' pay plan & benefits with liberal time off & vacations. Please contact R. Finn, (815)725-4631.

INTERNAL MEDICINE—Hospital based private practice; rural community near Eau Claire, Wisconsin; part-time satellite available. Call sharing and guarantees provided. Critical care management. Two hours to Minneapolis. Charles Nelson, Fox Hill Associates, 250 Regency Court, Waukesha, 53186, (414)785-6500.

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NEUROLOGIST—Exciting opening with group located 45 min. from Chicago. Group well established & has many resources: excellent physicians' pay plan & benefits with liberal time off & vacations. Please contact R. Finn (815)725-4631.

RADIOLOGY-LOCUMS, East Central Illinois. Board certified or eligible diagnostic radiologist needed twelve weeks a year. Excellent compensation. General diagnostic, ultrasound, nuclear medicine, C.T. required—for practice in 235 bed acute care hospital. Reply to Box # 1173, c/o *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

CARDIOLOGIST—Exciting opening with group located 45 min. from Chicago. Group well established & has many resources: excellent physicians' pay plan with liberal time off & vacations. Please contact R. Finn (815)725-4631.

FAMILY PRACTITIONER—Exciting opening with group located 45 min. from Chicago. Group well established & has many resources: excellent physicians' pay plan with liberal time off & vacations. Please contact R. Finn (815)725-4631.

EAR, NOSE, THROAT PRACTICE located in near NW suburb. Owner retiring. Practice grossing $100,000 on 20 hour work week, no surgery. Asking $50,000. Professional Practice Sales, 540 Frontage Rd., Northfield, IL. 60093; (312)441-6111.

OBSTETRIC/GYNECOLOGY—Exciting opening with group located 45 min. from Chicago. Group well established & has many resources: excellent physicians' pay plan with liberal time off & vacations. Please contact R. Finn (815)725-4631.

PRACTITONER/EMERGENCY ROOM Physician/Occupational medicine physician for a busy west suburban medical center. Full or part time. Salary and benefits. Possible partnership arrangement in 2 to 3 years. Send C.V. to Togen, Ltd., P.O. Box 31, Addison, Illinois 60101.

PEDIATRICIAN—Exciting opening with group located 45 min. from Chicago. Group well established & has many resources: excellent physicians' pay plan with liberal time off & vacations. Please contact R. Finn (815)725-4631.

SITUATIONS WANTED

PGY1-GRADUATE of the University of Alexandria Egypt—speaks English and French fluently. Uncle is a surgeon in Illinois (U.S. citizen), will sponsor me. Seeking residency in any surgical specialty (general, E.N.T., ophthalmology, orthopedics, urology, ob.gyn., dermatology). All requirements will be complied with. Reply to Box 1167, c/o *Illinois Medical Journal.* Twenty North Michigan Avenue, Suite 700, Chicago IL 60602.

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50% OFF PREVIOUSLY owned medical, laboratory, office, x-ray, and ultra-sound equipment in excellent condition. We buy, sell, broker, and repair. Office appraisals available by certified surgical consultants. Call Doctor Medical Resale Ltd., 16250 Northland Dr., Ste. LL026, Southfield, Mich. 48075. (313) 569-4407, 9a.m.-9p.m.

AN EXCELLENT INVESTMENT opportunity for a doctor. Buy a medical building in a prime Oak Park location. Good income. Easy to maintain. Plenty of parking. Call 312/ 251-3746 after 12:00 noon. $360,000.

SPORTS CAR FOR SALE. Brand new 1985 Mercedez Rare 280 SL with 5 speed. Imported from Europe. Gorgeous red. Loaded with European features, all options, leather, extra kinderseat for two kids. Hard and convertible tops. Powerful V6, 24 mpg. $41,900/ best offer including 4 year warranty. Call (312) 224-4500, Dr. Vijay or (312) 333-6789.

GO WEST ON I-80, For sale, attractive contract. Stop before the Mississippi River at Quad Cities, Illinis, fully equipped freestanding medical office building, downtown with nearby hospital; please phone Andy, evenings (319)-359-1039.

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Physicians, more than any other group with which I am familiar, address issues in a straightforward, honest fashion. In this spirit, I would like to share with you my impression that our membership must develop a somewhat disimpassioned political perspective. That perspective should encompass the many forces impinging upon our hospitals, our private offices, our teaching centers and our personal and family lives. These same forces secondarily affect our patients' care and, eventually, their personal and family lives.

By properly analyzing the various problems and developing scientific and/or practical solutions, a plan of action can be agreed upon. At this point, your hospital medical staff, county medical society or state medical society can help formulate and direct this plan. But cooperative, cohesive action will be needed to properly attack and correct or ameliorate these largely societal issues.

We need to be painfully honest with ourselves and our colleagues to address various "turf" issues, problems of unfair fees and reimbursement concerns. We must also be kind and judicious as we address the problems of physician impairment and the small percentage of true medical negligence incidents where compensation is indicated.

We must face these issues. It is not fair to our patients or society to ignore or excuse them, or to look the other way.

I have great confidence that the physicians of this state will properly address these problems and find solutions. Let us enroll more members to get more adequate representation and more fairly share the costs in time, effort, and finances. We must diagnose the problem, prescribe the therapy, and mobilize the effort to accomplish the task. Everyone will be a beneficiary if we can preserve the private practice of medicine and our free society. ◀

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THE VIEWBOX

CONTRIBUTING EDITOR TERRENCE C. DEMOS, M.D., PROFESSOR OF RADIOLOGY, DEPARTMENT OF RADIOLOGY, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was contributed by Michael C. McVeigh, M.D., Section of Nuclear Medicine, Department of Radiology, Loyola University Medical Center, Maywood.

This five year old girl fell and hit her left side on a bus seat. She then developed abdominal pain and tachycardia. An emergency liver spleen scan was done.

Figure 1
99m Technitium Sulfur Colloid Liver Spleen Scan. (L—liver; S—spleen).

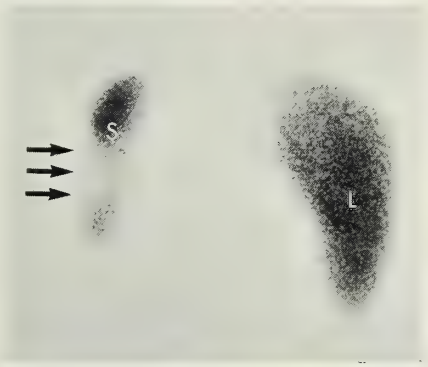


Figure 1A
Posterior view. Decreased activity over the lower two-thirds of the spleen (arrows).



Figure 1B
Same patient. LAO view. Large filling defect on lateral aspect of spleen corresponding to area of decreased activity above (arrows).

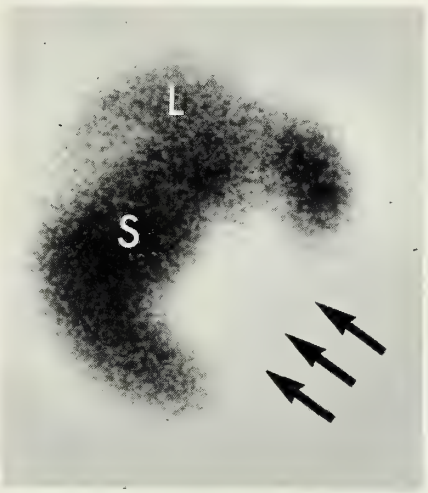


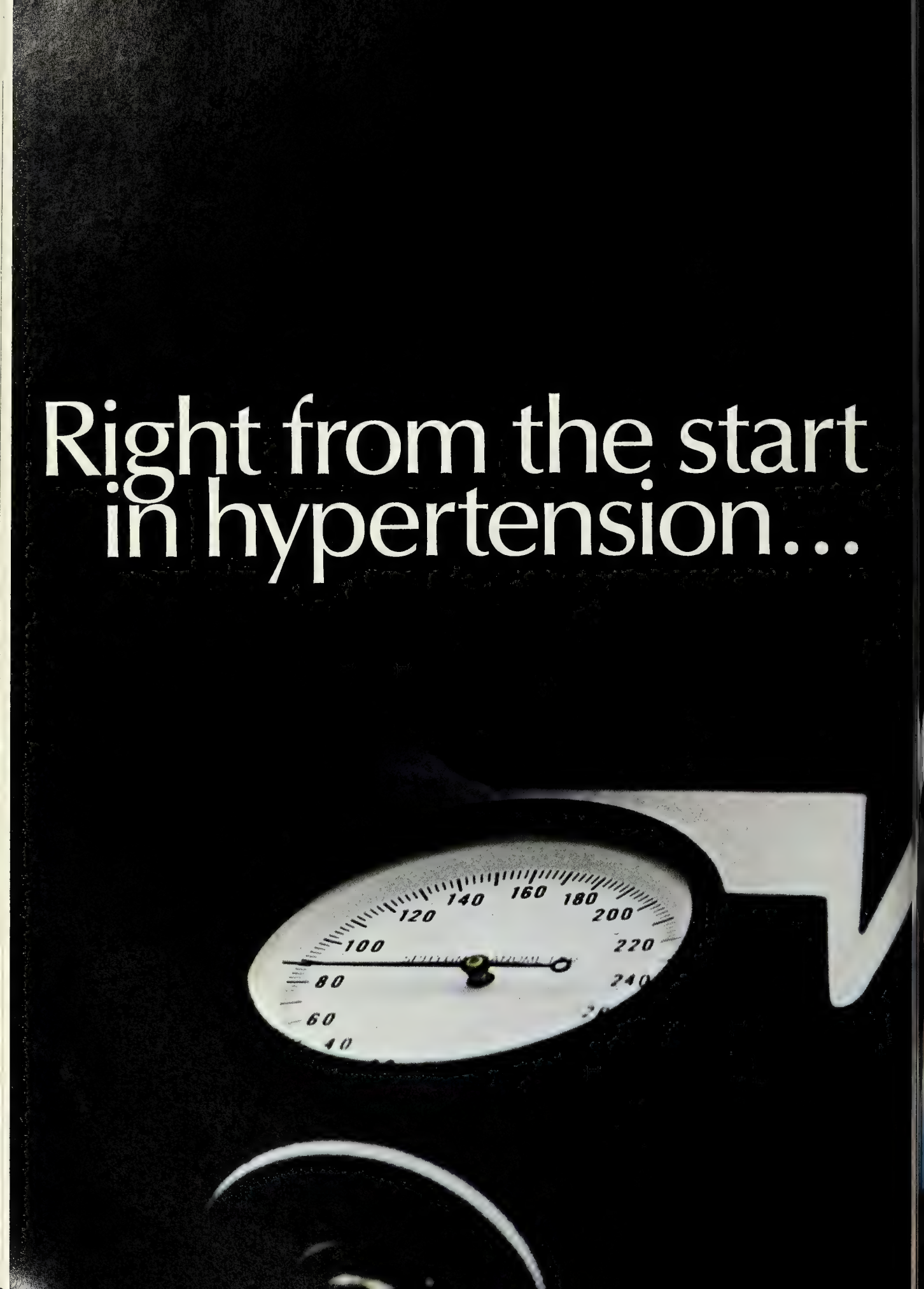
Figure 1C
Same patient. Left lateral view. Large filling defect on posterolateral aspect of spleen (arrows).

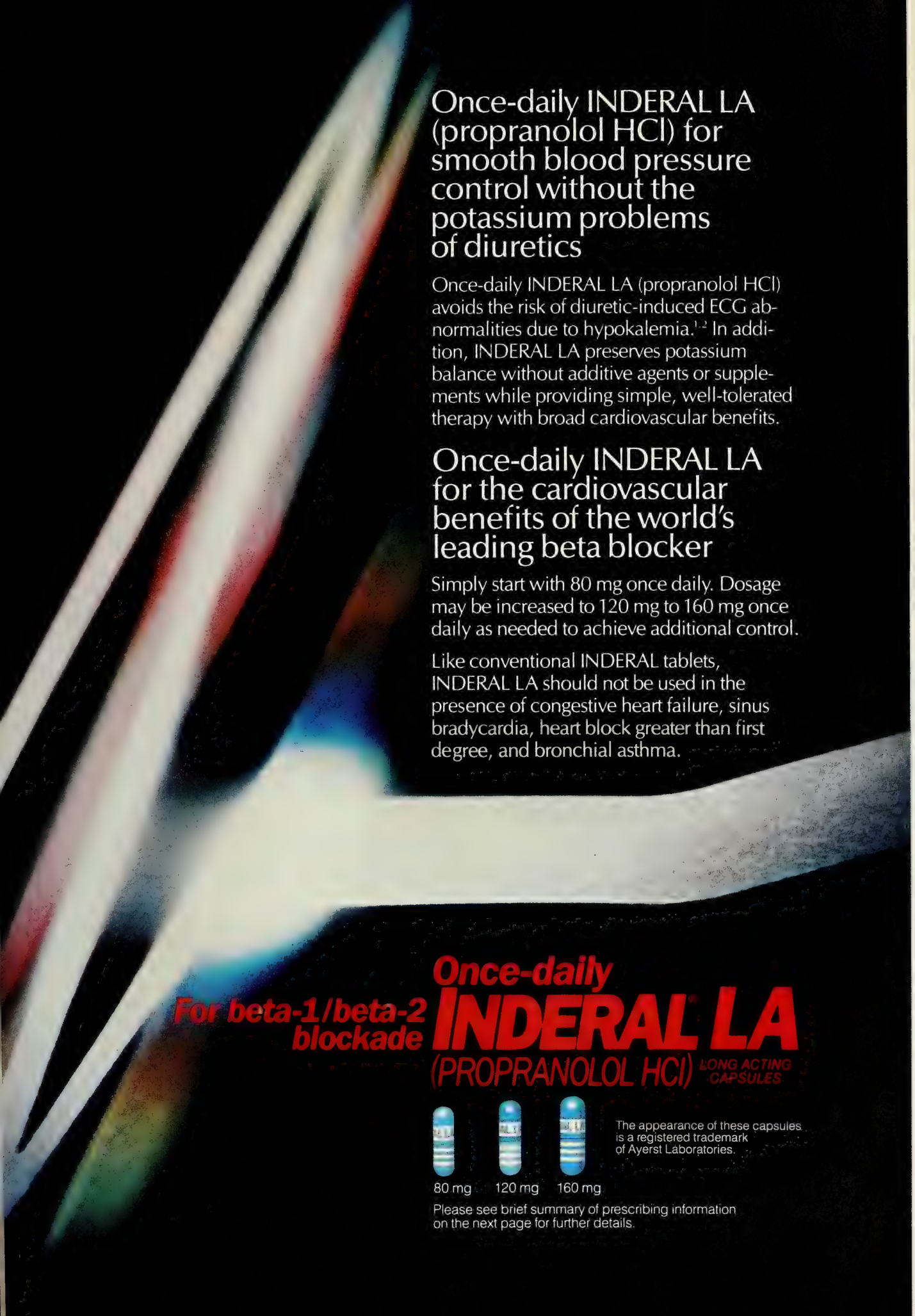
Your diagnosis?

(1) Splenic cyst
(2) Splenic infarct
(3) Subcapsular hematoma
(4) Hodgkin's disease
(5) Congenital splenic lobulation
(6) Splenic abscess

(Continued on page 176)

Right from the start in hypertension...





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Please see brief summary of prescribing information on the next page for further details.

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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy. Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

REFERENCES

1. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768. **2.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299.

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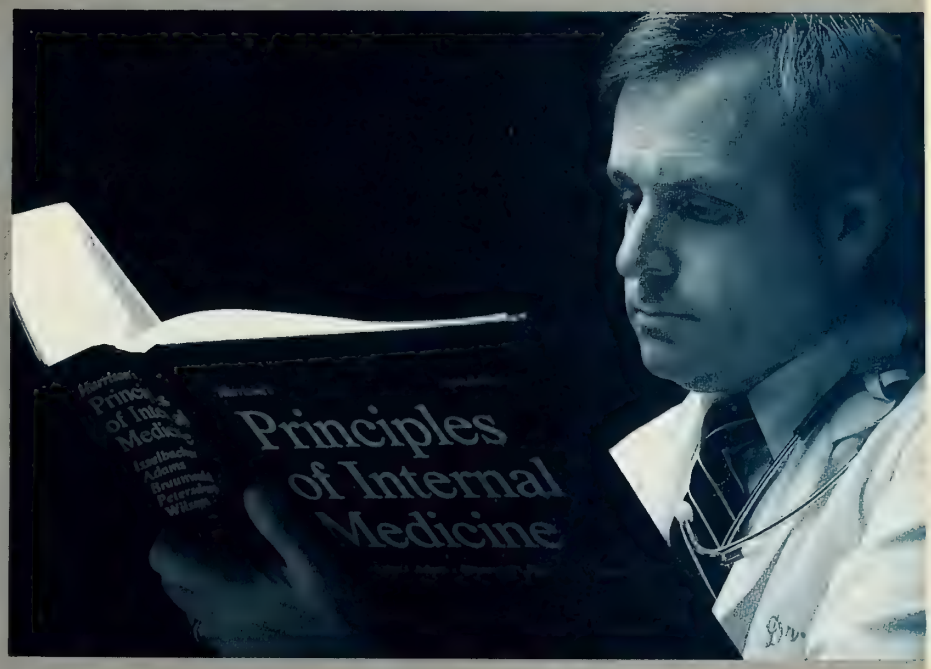
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OBITUARIES

***Allers, William D.,** LaGrange, died June 27, 1985 at the age of 78. Dr. Allers was a 1941 graduate of the Northwestern University Medical School, Chicago.

****Bartkus, Juozas,** Chicago, died June 29, 1985 at the age of 87. Dr. Bartkus was a 1923 graduate of the Vyteuta Didziojo Universiteto Medicinos Fakelteto, Kaunas, Lithuania.

***Borden, George,** Quincy, died June 24, 1985 at the age of 69. Dr. Borden was a 1940 graduate of the University of Illinois College of Medicine, Chicago.

****Calvin, Joseph K.,** Chicago, died July 11, 1985 at the age of 89. Dr. Calvin was a 1919 graduate of Rush Medical College, Chicago.

***Del Canto, Policarpo,** Richton Park, died July 15, 1985 at the age of 69. Dr. Del Canto was a 1941 graduate of the Facultad de Medicina de la Universidad de Santiago de Compostela, Santiago de Compostela, Spain.

Dow, James W., Hanover Park, died June 4, 1985 at the age of 67. Dr. Dow was a 1944 graduate of the Tufts University School of Medicine, Boston.

***Falconer, Everett G.,** Seward, died June 28, 1985 at the age of 73. Dr. Falconer was a 1938 graduate of the University of Illinois College of Medicine, Chicago.

***Kaufman, Jerome D.,** Encino, California, died July 4, 1985 at the age of 74. Dr. Kaufman was a 1936 graduate of the University of Illinois College of Medicine, Chicago.

***Landis, James W.,** Olney, died July 10, 1985 at the age of 64. Dr. Landis was a 1944 graduate of the University of Illinois College of Medicine, Chicago.

****Matthei, Charles H.,** Downers Grove, died June 11, 1985 at the age of 86. Dr. Matthei was a 1935 graduate of the University of Health Sciences/Chicago Medical School.

****Schwied, Samuel,** Niles, died July 8, 1985 at the age of 77. Dr. Schwied was a 1930 graduate of the University of Illinois College of Medicine, Chicago.

Slight, David, Chicago, died July 18, 1985 at the age of 86. Dr. Slight was a 1922 graduate of the Faculty of Medicine University of Edinburgh, Edinburgh, Scotland.

***Taubert, Russell K.,** Pekin, died July 20, 1985 at the age of 72. Dr. Taubert was a 1936 graduate of the University of Illinois College of Medicine, Chicago.

Wachter, Ronald E., Waukegan, died June 2, 1985 at the age of 53. Dr. Wachter was a 1957 graduate of the University of Health Sciences/Chicago Medical School.

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*

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ISMS All-Member Conference to Offer Strategies

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With a theme of "Blueprint for Action: ISMS Directions for 1986 and 1987," the Illinois State Medical Society's 1985 All-Member Conference will explore new strategies designed to help physicians meet the challenges cited above. The two day meeting, slated for November 2-3, 1985 will convene in Peoria at the Continental Regency Hotel. All ISMS members are welcome.

The program will begin with a discussion of "The Case For Physician Action." A panel of experts—including J. Paige Clousson, J.D., contract negotiations consultant; Alfred J. Clementi, M.D., chairman of the ISMS Board of Trustees; and James L. Fletcher, J.D., ISMS special counsel—will explore the wide variety of financial and service contracts being offered to physicians and will suggest possible legislative remedies to existing problems.

Also on the agenda is an in-depth view of Illinois' newly-enacted medical malpractice law, from the perspective of those most closely involved with its passage. House Minority Leader Rep. Lee Daniels (R-Elmhurst), a DuPage County attorney who led the reform fight, will address conference participants. Special attention will be given to physician participation on pre-trial screening panels and the need for future tort reform initiatives.

Fred Graham, CBS network television legal correspondent, will provide a unique perspective of our nation's civil justice system. From the viewpoint of both attorney and journalist, Graham will examine the system's modern day ailments and public perceptions on the need for change. Joining Graham on this year's program will be Robert Teeter, president of Market Opinion Research. Teeter will discuss "Image Building for Medicine" describing current public perceptions of doctors, and how the profession can act to improve them.

Several workshops will offer practical, hands-on approaches to the following topics:

- Joint ventures;
- Organizing an effective hospital medical staff;
- Assuring the competency of hospital medical staff members;
- Public speaking for physicians;
- Physician contracting and PPOs; and
- Individual Practice Associations.

For those involved in grassroots political and legislative action on medical malpractice, the all-member conference will present new directions, issues and methods for advocacy by hospital action teams. The already-emerging 1986 state election contests will be previewed. And a look at the 'nuts and bolts' of running effective state legislative campaigns and opportunities for physician involvement also will be presented.

Further information and registration materials will be sent to all ISMS members in advance of the conference. ◂

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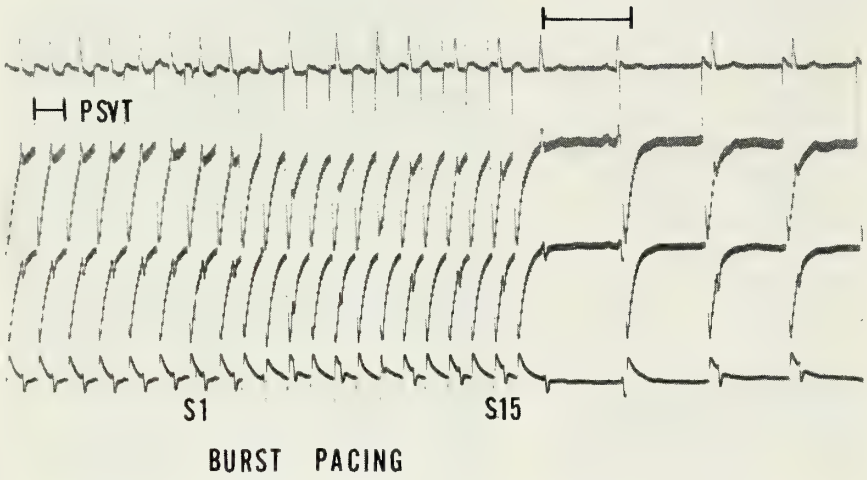
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EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This month's EKG was prepared by Dr. Ronald Walsh, D.O., Olympia Fields Osteopathic Medical Center, Olympia Fields, Illinois.



This patient is a 48 year old lady who was referred for complaints of palpitations and chest pain. These complaints had been present for 12 years but had increased in frequency and duration. A typical attack of palpitations would last 10-15 minutes, but recently they had lasted three to four hours. These longer episodes required hospitalization and direct current cardioversion because of hypotension on several occasions. Her physical examination was entirely normal except for mild orthostatic hypotension. All admission laboratory tests, including thyroid function, were normal. A resting electrocardiogram and a chest x-ray were normal. The clinical association of chest pain and palpitations had led to a normal coronary arteriogram at another hospital. This ECG was taken during a special study.

Questions:

1. **The ECG in the top strip shows:**
 a. Paroxysmal supraventricular tachycardia (PSVT).
 b. Paroxysmal ventricular tachycardia.
 c. Atrial fibrillation.
 d. Fascicular tachycardia.
 e. Atrial flutter.

2. **Management of this patient could include:**
 a. Electrophysiologic testing to include serial drug testing.
 b. Digoxin.
 c. Quinidine, procainamide.
 d. Disopyramide, propranolol.
 e. A tachycarrhythmia terminating pacemaker.

(Continued on page 175)

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AMA-MSS and AMA-HOD Respond

Proposed FAA Regulations on Medical Kits

By Jack M. Whitney III

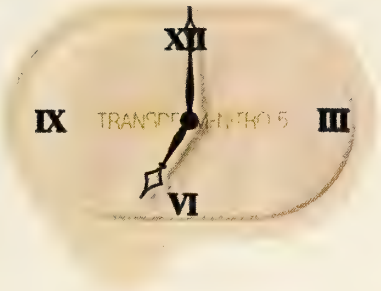
During the annual meeting of the AMA-HOD this June, two resolutions were submitted in response to a Federal Aviation Administration (FAA) proposed rule establishing requirements for emergency medical kits on commercial aircraft. The FAA proposed rule includes an inventory of pharmaceuticals for treatment of arrhythmias, seizures, emesis, hypoglycemia, allergic reactions and angina. The rule also requires instruments including: a stethoscope, sphygmomanometer, airway adjuncts, hemostats and a scalpel. One resolution was submitted by W. Benson Harer, Jr., M.D., a member of the California delegation. It asked that the AMA promptly convey its support for provision of a basic medical emergency kit on all commercial aircraft carrying 60 or more passengers. A second resolution was drafted by Gail Herman, a fourth year medical student at the University of Illinois College of Medicine at Chicago. This resolution, submitted by the AMA-MSS, asked that the AMA study the feasibility of having certain life-saving drugs stocked on board commercial aircraft and report their findings at the 1986 annual meeting. As the AMA-MSS delegate from the University of Illinois College of Medicine at Chicago, I followed closely the testimony given and action taken on these two resolutions in reference committee and on the floor of the AMA-HOD.

In reference committee testimony and materials critiquing the FAA proposed rule were submitted by Dr. Harer, Richard L. Stennes, M.D., F.A.C.E.P., and myself. Dr. Harer's comment reviewed previous AMA policy, which supports requirements for a stethoscope, sphygmomanometer, airways, splints, tongue blades and a flashlight, as well as, collection of data concerning the number and frequency of in-flight medical emergencies. He urged adoption of his resolution and a timely response by the AMA to the FAA proposed rule.

Dr. Stennes' testimony supported both resolutions and he submitted comment on the FAA proposed rule which had been forwarded from the American College of Emergency Physicians (ACEP). The ACEP proposal includes a stethoscope, flashlight, airway equipment, laryngoscope, hemostats, scalpel and scissors. The ACEP proposal deletes the following drugs from the FAA rule inventory: sodium bicarbonate, amobarbital, prochlorperazine, adrenocortical steroid, and aminophylline. ACEP's comment requested the addition of ipecac and donnatal to the pharmaceutical inventory. ACEP's proposal defined the personnel qualified to utilize the kit as physicians, nurses with special training, and paramedics.

Testimony from the AMA-MSS reviewed the population involved, the medical risks associated with flight, and current resources for in-flight emergency care. Each year, over 300 million people are transported by commercial aircraft regulated by the FAA. People with compromised cardiac or pulmonary function are exposed to a stressful environment with a decreased partial pressure of oxygen, even in pressurized cabins. Another form of medical risk is the delayed access to definitive medical care. Although many commercial aircraft can rapidly divert to nearby landing sites, approach, landing and docking times can result in an extended delay in access to pre-hospital advanced cardiac life support or transport to a definitive treatment site. Emergency care is currently provided by flight attendants trained in CPR and first aid, or

(Continued on page 148)



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This drug product has been conditionally approved by the FDA for the prevention and treatment of angina pectoris due to coronary artery disease. The conditional approval reflects a determination that the drug may be marketed while further investigation of its effectiveness is undertaken. A final evaluation of the effectiveness of the product will be announced by the FDA.

CONTRAINDICATIONS
Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued.
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Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities.
The usual dosage is one Transderm-Nitro 5 system every 24 hours. Some patients, however, may require the Transderm-Nitro 10 system. If a single Transderm-Nitro 5 system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 systems or one Transderm-Nitro 10 system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone.
The optimal dosage should be selected based upon the clinical response, side effects, and the effects of therapy upon blood pressure. The greatest attainable decrease in resting blood pressure that is not associated with clinical symptoms of hypotension especially during orthostasis indicates the optimal dosage. To decrease adverse reactions, the size and/or number of systems should be tailored to the individual patient's needs.
Do not store above 86°F (30°C).

PATIENT INSTRUCTIONS FOR APPLICATIONS
A patient leaflet is supplied with the systems.

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10 mg/24 hr	50 mg	20 cm^2	30 Systems (NDC 0083-2110-26) *100 Systems (NDC 0083-2110-30)
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MSS in Action

(Continued from page 146)

medical personnel offering voluntary aid. The required first aid kit was designed in 1924. It contains bandages, dressings and splints, and is often poorly maintained.

Commentary on the prepared testimony elicited a definition of medical personnel qualified to utilize the kit as a physician, physician assistant, nurse, nurse practitioner, or emergency paramedic with advanced cardiac life support certification by the American Heart Association, or an equivalent level of training and certification.

The reference committee recommended Dr. Harer's resolution for adoption by the AMA-HOD. The AMA-MSS resolution was recommended for referral to the AMA Board of Trustees. The actions of the AMA-HOD followed the recommendations of the reference committee.

The AMA responded to the FAA proposed rule by forwarding the policy reviewed by Dr. Harer's testimony. A cover letter from James H. Sammons, M.D., executive vice-president of the AMA, requests that the rule be withdrawn, and the FAA follow the recommendations of the AMA policy statement.

After review of the submitted comments, the FAA may issue the rules unchanged, amend rules and issue its final regulation, or withdraw the proposal. These rules have a long regulatory and judicial history and withdrawal is unlikely. Physicians and other qualified medical personnel will need to be alerted to the final form of the FAA regulation, and informed of the credentialing and reporting requirements associated with use of the kit. Methods for transfer of medical control of care from the aircraft provider to personnel responding to the airport will need to be specified by local pre-hospital emergency care providers. Review of the response to the FAA proposed rule by the AMA-MSS, AMA-HOD and ACEP demonstrates how the student section, physicians and specialty members can work to positively affect proposed government regulatory action. ◀

It Ain't Over 'Til It's Over

Maintaining Momentum

By George T. Wilkins, Jr., M.D., Chairman, IMPAC

Twenty five years ago, a small group of physicians and auxilians formed the Illinois State Medical Society Political Action Committee (IMPAC), the first medical political action committee in the country.

At that time, there were many members of the medical community who were not sure that medicine belonged in the political arena.

How times have changed!

Today, physicians and auxilians are among the most politically active groups in the country.

This fact was demonstrated on May 22nd, when 4,000 physicians and auxilians gathered in Springfield to demonstrate their support for the professional liability package. Everyone who attended the legislative rally had to feel as I did—that our presence in Springfield on May 22nd played a major role in our eventual success.

We have determined that a majority of those attending the rally had taken one extra step—they had joined IMPAC. Many physicians and auxilians wore their Super Sustaining pins that day. It was clear to members of the legislature that medical families had not only invested time but also had realized the importance of participating in the political process.

A majority of the members of the General Assembly have received contributions from IMPAC. When a candidate or member of the state assembly receives a contribution from IMPAC, he or she is made aware that this contribution is only possible through the generosity of physicians and auxilians who understand the importance and necessity of medical involvement in the political process.

Not every candidate for political office is eligible for an IMPAC contribution. Our first priority is, of course, helping our friends. Medicine is fortunate to have many good friends in Springfield and it is in our best interest to assist them in their efforts to remain in office.

In each election cycle, a number of incumbents leave office for one reason or another. These open seats present opportunities for IMPAC to recruit and assist candidates whose philosophies are similar to that of medicine. IMPAC has also been successful in recruiting candidates to oppose incumbents whose voting records do not reflect the views of medicine.

Over the years IMPAC has participated in hundreds of elections. In 1984, for example, IMPAC was involved in 158 legislative races and several judicial and congressional races. We were very pleased to achieve a 90% success ratio.

There are no strings connected to an IMPAC contribution. All that is asked is that the concerns of medicine receive a fair hearing when brought before the members of the General Assembly. I think that we have been most successful in relaying that message, particularly given the opposition we faced with our efforts in the professional liability initiative.

Medicine enjoyed a great victory in early summer. We are one of the first states to pass a comprehensive malpractice package. It would be easy now for us to say that our job is done. It would be easy to say that we have accomplished our objectives and can now move on to other things. But that would be a mistake. Physicians and auxilians must be prepared to participate in the primary election on March 18, 1986 and in the general election on November 4, 1986.

The governorship and other members of the executive branch of the state of Illinois will be up for election. All 118 members of the House of Representatives and 39 members of the Illinois State Senate will be before the voters. The entire congressional delegation, plus one of our U.S. Senate seats, will also be up for re-election.

The candidates elected in 1986 will be the legislators who will debate medical legislation in 1987, the year in which we will return to the General Assembly to gain passage for the remainder of our professional liability package, namely a cap on non-economic losses.

In the last year, physicians have developed a more significant presence in Springfield. In order to maintain the credibility we have established, we must continue our involvement in the political process, through contributions to IMPAC, personal involvement in campaigns and action teams.

When you are asked to make a contribution to IMPAC, please give it serious consideration. Remember that we moved mountains in 1985. We can reinforce and sustain that progress if we all work together. ◀

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2 & 110.5. (Federal regulations require this notice.) IMPAC reports are filed with the State Board of Elections and are or will be available for purchase from the State Board of Elections, 1020 South Spring St., Springfield, Illinois, 62704.

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

OCTOBER

Cardiology
Practical Aspects of Vascular Disease
For: Physicians and other health professionals. Conference, October 4, Madison, Wisconsin. **Sponsor:** University of Wisconsin Medical School Departments of Family Medicine, Radiology and Surgery, 465 WARF Bldg., 610 Walnut, Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 7 hours; AOA Category 2-D, and University of Wisconsin CEU's: 7 hours. **Contact:** Sarah Aslakson, Program Coordinator. **Phone:** (608) 263-2856.

Echocardiography
For: Cardiologists, Echocardiographers, Field technical specialists. Course and Workshop, October 22-25, Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60610. **Fee:** $350. **Reg. Limit:** 250. **Credit:** Category I: 26 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Cardiology
Considerations in Coronary Artery Disease
For: Internists, Cardiologists, Family Practice. Symposium, October 9, Holiday Inn Westport, St. Louis MO. **Sponsor:** St. Louis University School of Medicine, CME, 1402 S. Grand Blvd., St. Louis, MO 63104. **Fee:** $45. **Reg. Limit:** None. **Credit:** Category 1: 6 hours; AAFP Prescribed: 6 hours; AOA: 6 hours. **Contact:** Anita Herbst. **Phone:** (314) 664-9800.

Neurology
Clinical Neuroimmunology Conference
For: Neurologists. Course, October 31-November 2. **Sponsor:** The University of Chicago, 5841 Maryland, Box 139, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** AMA Category 1: To be determined. **Contact:** Marlene Goldberg, Conference Mgr. **Phone:** (312) 962-1056.

Neurology
Current Trends and Future Directions in Parkinsonism
For: Neurologists, neurosurgeons, internists, family practitioners, and gerontologists. Symposium, October 8, 8:00 a.m. -12:30 p.m., Northwestern University Alumni Center, 303 E. Chicago, Ave., Chicago, IL 60611. **Sponsors:** Northwestern University Medical School Dept. of Neurology and the American Parkinson Disease Association. **Fee:** $35. **Reg. Limit:** 250. **Credit:** Category 1: 4 hours. **Contact:** Jeanne Toguri. **Phone:** (312) 649-8989.

Psychiatry
The Psychiatric Interview
For: Psychiatrists. Course, October 18-20. **Sponsor:** The University of Chicago, 5841 Maryland, Box 139, Chicago, IL 60637. **Place:** Chicago Hilton and Towers. **Fee:** $375. **Reg. Limit:** None. **Credit:** AMA Category 1: 17 hours. **Contact:** Marlene Goldberg, Conference Mgr. **Phone:** (312) 962-1056.

Psychiatry/Pediatrics/Nutrition
Eating Disorders
For: Physicians and other health professionals. Conference, October 11-12. **Sponsor:** University of Wisconsin Department of Pediatrics; Eating Disorder Clinic-University of Wisconsin, 465 WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: To be determined; ADA: Pending; AOA Category 2-D; WNA Pending; and University of Wisconsin CEU's. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Critical Care
Fourth Annual Chicago Critical Care Symposium
For: Physicians and nurses and other health professionals. Lectures, Tutorials, October 10-13 at Chicago Marriott Hotel. **Sponsor:** The Chicago Medical School, University of Health Sciences, 3333 Green Bay Rd., North Chicago, IL 60064. **Fee:** Physicians: $375.; residents and allied health professionals: $250. **Reg. Limit:** None. Reg. Deadline: October 8. **Credit:** AAFP Prescribed: 24 hours; Category 1: 24 hours; ACCN: 24 hours pending approval; ACEP: 24 hours pending approval; AARP: 24 hours pending approval. **Contact:** Sybil Michaels. **Phone:** (312) 578-3292.

Otolaryngology
Otolaryngology Head and Neck Laser Workshop
For: Otolaryngologists, D.O.'s and D.O.V.'s. Workshop, October 6-8. **Sponsor:** Northwestern University Medical School, 301 East Chicago Avenue, Chicago, IL 60611. **Fee:** $1,000. **Reg. Limit:** 15. **Credit:** Category 1: 20 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Nutrition/Oncology/General Practice
Frontiers of Nutrition and Cancer
For: Physicians and other health care professionals. Symposium, October 17-18. **Sponsors:** University of Wisconsin CME; Wisconsin Nutrition Council; Dept. of Nutritional Sciences, University of Wisconsin, Madison; Clinical Nutrition Center, University of Wisconsin-Madison; Medical College of Wisconsin, Milwaukee; American Cancer Society; and Wisconsin Dietetic Association. Address: 465B WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 11 hours; University of Wisconsin CEU's and AOA's: Approx. 11 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Internal Medicine & Family Practice
Midwestern Conference on Health Care in the Elderly
For: Physicians, nurses, social workers, and nursing home administrators. Symposium, October 18-19; 8:00 a.m.—5:00 p.m. **Sponsor:** University of Iowa College of Medicine, Continuing Medical Education, 285 Med Labs, Iowa City, IA 52242. **Fee:** $150/M.D.'s, $75/allied health. **Reg. Limit:** None. **Credit:** Category 1: approx. 10 hours; nursing credit; nursing home administrator CEU's. **Contact:** R.M. Caplan, M.D. **Phone:** (319) 353-5763.

Rheumatology
Focus on Rheumatology-1985
For: Physicians and other health professionals. Conference, October 18-19. **Sponsor:** University of Wisconsin, CME and Department of Medicine, 465B WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 9 hours; AAFP Prescribed 8½ hours; AOA Category 2-D: 8½ hours; and University of Wisconsin CEU's: 9 hours.

Obstetrics/Gynecology
Blue Ribbon Baby: Quality Care from Conception to Birth
For: Ob/Gyn M.D.'s, RN's and Midwives. Lecture/Workshop, October 3-4, 8:00 A.M.—5:00 P.M., Oak Brook. **Sponsor:** Rush University, Continuing Medical Education, 600 S. Paulina, Chicago, IL 60612. **Fee:** None. **Credit:** Category 1: 12 hours; ACOG applied for. **Contact:** Barbara Trejo. **Phone:** (312) 942-7119.

Endocrinology
Encocrinology Conference
For: Physicians and other medical professionals. October 10, 1:00 p.m.-5:30 p.m., Lincoln, IL. **Sponsor:** Southern Illinois University School of Medicine. **Fee:** $25. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean for CME. **Phone:** (217) 782-7711.

Neurology/OB-GYN/Psychiatry/Plastic Surgery
China Explorers Cruise Medical Seminar at Sea
For: Physicians and other health care professionals. October 8-21. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $600. **Reg. Limit:** None. **Credit:** Category 1 and AAFP Prescribed: 60 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean for CME. **Phone:** (217) 782-7711.

Cardiology
Doppler and Two Dimensional Echocardiography Workshop: New Advances in Pulsed, Continuous Color Doppler. **For:** Physicians and echocardiography technicians. Lectures and Workshops, October 22-25, 8:30-4:30, Chicago, IL. **Sponsor:** Northweatern University Medical School, 250 E. Superior (Wesley-586), Chicago, IL 60611. **Fee:** $350. **Reg. Limit:** 180. **Reg. Deadline:** October 4. **Credit:** Category 1: 26 hours. **Contact:** Sharon Baruch. **Phone:** (312) 908-4687.

Surgery
Specialty Review in General Surgery, Part 1
For: general and specialized surgeons. Lecture, October 21-November 1, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $840. **Reg. Limit:** None. **Credit:** Category 1: 97 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Cardiology/Surgery/Family Practice
Practical Aspects of Vascular Disease
For: Physicians and other health professionals. Conference, October 4, Madison, WI. **Sponsors:** University of Wisconsin-CME and Department of Family Medicine, 465 WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 7 hours; AAFP Elective: 7 hours; AOA Category 2-D and University of Wisconsin CEU's: 7 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Internal Medicine
Specialty Review in Cardiovascular Disease
Internists, cardiovascular specialists. Lecture, October 7-11, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Fee:** $615. **Reg. Limit:** None. **Credit:** Category 1: 40 hrs. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Specialty Review in Gastroenterology
For: Internists and gastroenterologists. Lecture, October 14-18, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Fee:** $615. **Reg. Limit:** None. **Credit:** Category 1: 40 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Surgery
Specialty Review in Pediatric Surgery
For: Surgeons. Lecture, October 9-12, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $530. **Reg. Limit:** 90. **Credit:** Category 1: 35 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Advanced Peripheral Vascular Surgery
For: Peripheral vascular surgeons. Lecture, October 7-11, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Fee:** $530. **Reg. Limit:** 90. **Credit:** Category 1: 32 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Pathology
Anatomic Pathology: A Comprehensive Review and Update
For: Pathologists. Lecture, October 12-16, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Fee:** $550. **Reg. Limit:** 90. **Credit:** Category 1: 44 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Clinical Pathology: A Comprehensive Review and Update
For: Pathologists. Lecture, October 17-20, Chicago. **Sponsor:** Cook County Graudate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Fee:** $550. **Reg. Limit:** 90. **Credit:** Category 1: 37 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Pathology
Perspectives in Pathology
For: Pathologists. Symposium, October 14, 7:00 P.M., Drake Hotel, Chicago, IL. **Sponsor:** Chicago Pathology Society and Michael Reese Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall Short, M.D., Pathology Dept., Loretto Hospital, 645 S. Central Avenue, Chicago, IL 60644

Family Medicine
Current Cardiology
For: Family and general practitioners, internists. Lecture, October 28-31, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Fee:** $395. **Reg. Limit:** 90. **Credit:** Category 1: 27 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Obstetrics/Gynecology
Specialty Reivew in Obstetrics and Gynecology
For: Obstetricians and gynecologists. Lecture, October 28-November 2, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Fee:** $660. **Reg. Limit:** 90. **Credit:** Category 1: 55 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Gynecology: Laser Medicine and Surgery at Northwestern Memorial Hospital
For: Physicians, medical students, nurses and related paramedicals. Seminar, October 14, 5-6:30 P.M., Alumni Center, Northwestern University Medical School. **Sponsor:** Northwestern Memorial Hospital Laser Committee. **Fee:** None. **Contact:** Elaine Brown. **Phone:** (312) 908-4480.

Dermatology
Advances in Therapy in Dermatology
For: dermatologists, general internists, and allergists. Lectures, October 18-November 1. China and Hong Kong trip. **Fee:** $300. **Reg. Deadline:** September. **Sponsor:** Northwestern University Medical School Department of Dermatology and the University of California. **Contact:** Henry 'Roenigk, Jr., M.D. **Phone:** (312) 649-8173.

Internal Medicine/Family Medicine/Emergency Medicine
Respiratory Critical Care Conference
For: Physicians, nurses, respiratory therapists, and other health care professionals. Conference, October 31-November 1, Madison. **Sponsor:** University of Wisconsin-CME and Department of Medicine, 465 WARF Bldg., 610 Walnut St., Madison, WI 53705. **Fee:** To be determined. **Credit:** Category 1: Approx. 12 hours; University of Wisconsin CEU's: approx. 12 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Family Practice/Internal Medicine/Neurology
1985 Conference on Back Pain Rehabilitation
For: Physicians, allied health personnel, and related professionals. Conference, October 25-26, Appleton, WI. **Sponsors:** University of Wisconsin-Madison, CME, 465 WARF Bldg; 610 Walnut Street, Madison, WI 53705 and Theda Clark Regional Medical Center, Neenah, WI. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: approx. 11 hours; Continuing Education Hours: approx. 11 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

NOVEMBER

Pediatrics
Intensive Course in Pediatric Nutrition
For: Physicians, interested allied health. Symposium, November 11-15, Iowa City, IA. **Sponsor:** University of Iowa College of Medicine Dept. of Pediatrics, UI Hospitals & Clinics, Iowa City, IA 52242. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: approx. 33 hours. **Contact:** Samuel J. Fomon, M.D. at the above address.

Seminars in Pediatrics
For: Physicians and pediatric nurses. Conference, November 1-2, Madison, WI. **Sponsors:** University of Wisconsin, Madison-CME and Department of Pediatrics, 465 WARF Bldg., 610 Walnut Street, Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 11 hours; AAFP Prescribed: 10.75 hours; AOA Category 2-D; University of Wisconsin CEU's: 11 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Geriatrics
Fourth Annual Symposium on Geriatric Medicine
For: Physicians. Symposium, November 6, Holiday Inn Westport, St. Louis, MO. **Sponsor:** St. Louis University School of Medicine, CME, 1402 South Grand Blvd., St. Louis, MO 63104. **Fee:** $45. **Reg. limit:** None. **Credit:** Category 1: 6 hours. **Contact:** Anita Herbst. **Phone:** (314) 664-9800.

Otolaryngology
Otolaryngology Head and Neck Workshop
For: Otolarynologists, D.O.'s, D.O.V.'s. Workshop, November 10-12. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $1,000. **Reg Limit:** 15. **Credit:** Category 1: 20 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Pathology
Panel on Problem Areas in Cytopathology
For: Pathologists and cytopathologists. Symposium, November 11, 7:00 P.M., Drake Hotel, Chicago, IL. **Sponsors:** Chicago Pathology Society and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall Short, M.D., Dept. of Pathology, Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644.

OB/GYN
Hysteroscopy Workshop
For: Obstetricians, gynecologists. Workshop, November 15-16, Chicago, IL **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $300. **Reg. Limit:** 200. **Credit:** Category 1: 9 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Neurosurgery
Neurosurgery Laser Workshop
For: Neurosurgeons. Workshop, November 18-19, Chicago, IL. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $900. **Reg. Limit:** 12. **Credit:** Category 1: 19 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Anesthesia
Workshop in Fiberoptic Endoscopy
For: Anesthesiologists. Workshop, November 23, Chicago, IL. **Sponsor:** Northwestern University Medical School, 301 East Chicago Avenue, Chicago, IL 60611. **Fee:** $225. **Reg. Limit:** 40. **Credit:** Category 1: 1 hour. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Internal Medicine
Advances in Internal Medicine 1985
For: Internists, November 11-15. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $500. **Reg. Limit:** 90. **Credit:** Category 1: 35 hours. **Contact:** Robert J. Baker, M.D. **Phone:** in Illinois: (800) 621-4649; outside Illinois (800) 621-4651.

Surgery
Fiberoptic Esophagogastric Endoscopy
For: Surgeons, internists, gastrocnterologists. Lecture with workshop, November 11-13. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $490. **Reg. Limit:** 15. **Credit:** Category 1: 16 hours. **Contact:** Robert J. Baker, M.D. **Phone:** in Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Flexible Fiberoptic Sigmoidoscopy
For: Surgeons and internists. Lecture with workshop, November 16, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $145. **Reg. Limit:** 75. **Credit:** Category 1: 7 hours; AAFP Prescribed: 7 hours **Contact:** Robert J. Baker, M.D. **Phone:** in Illinois: (800) 621-4649; outside Illinois:(800) 621-4651.

Dermatology/Laser
Dye Lasers in Dermatology; Laser Medicine and Surgery at Northwestern Memorial Hospital Seminar Series
For: Physicians, medical students, nurses, and related paramedicals. Seminar, November 11, 5-6:30 p.m., Northwestern University Medical School Alumni Center, 303 E. Chicago Avenue, Chicago, IL 60611. **Sponsor:** Northwestern Memorial Hospital Laser Committee. **Fee:** None. **Reg. Limit:** None. **Credit:** None. **Contact:** Elaine Brown. **Phone:** (312) 908-4480.

DECEMBER

Pathology
Symposium on Recent Advances in Clinical Microbiology
For: Pathologists and microbiologists. Symposium, December 9, 7:00 p.m., Drake Hotel, Chicago. **Sponsors:** Chicago Pathology Society and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall Short, M.D., Dept. of Pathology, Loretto Hospital, 645 S. Central Avenue, Chicago, IL 60644.

Neurology
Neurology for the Non-Neurologists
For: Family Practitioners, Internists and Psychiatrists. Lectures, workshops, December 4-5, 8:30 a.m.-5:00 p.m. and December 6, 8:30 a.m.-3:30 p.m. **Sponsor:** Rush University and Rush-Presbyterian St. Luke's Medical Center CME, 600 S. Paulina, Chicago, IL 60612. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 20 hours; AAFP Elective: 20 hours. **Contact: Barbara Trejo. Phone:** (312) 942-7095.

Gynecology
Problem Solving in Gynecologic Encocrinology and Infertility
For: Gynecologists. Course, December 6-7, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Catgory 1: 10 hours; ACOG: 10 Cognates. **Contact:** Marlene Goldberg. **Phone** (312) 962-1056.

Cardiology
Cardiology Conference
For: Physicians and other medical professionals. Conference, December 6, Springfield, IL. **Sponsor:** Southern Illinois University School of Medicine, Box 3926, Springfield, IL 62708. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 7 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean, CME. **Phone:** (217) 782-7711.

Third International Symposium on Electrophysiologic Basis for Diagnosis and Management of Cardiac Arrhythmias
For: Physicians, cardiac technologists, and nurses. Symposium, December 27-30, Orlando, FL. **Sponsors:** University of Wisconsin-Madison, CME; Mt. Sinai Medical Center, Milwaukee; American Heart Association; Florida Heart Institute, Orlando, FL; and Continuing Research Foundation, Elm Grove, WI. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 19 hours; AAFP **Elective:** 19 hours; AOA Category 2-D, University of Wisconsin CEU's: 19 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Emergency Care
Trauma
For: Physicians, and emergency care professionals. Symposium, December 5, 3:00-7:00 p.m., Quincy, IL. 'Sponsor: Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean for CME. **Phone:** (217) 782-7711.

Self-Directed Learning
The Gold Standard

In recognition of the many changes occurring in the past years over the issues of mandatory and voluntary CME, the Illinois Council on Continuing Medical Education will address this timely and substantive topic at the Thirteenth Annual Congress on CME.

Date: October 11-12, 1985
Place: Arlington Park Hilton, Arlington Heights, IL
Credit: Nine hours Category 1 AMA/PRA

In an effort to assess alternative methods of providing continuing medical education for the individual physician, Congress participants will learn from keynote speakers:

Robert K. Richards, Ph.D.
Assistant Dean, Associate Professor
Michigan State University, College of Human Medicine
Grand Rapids, MI

and

Alan B. Knox, Ph.D.
Professor, Continuing and Vocational Education
University of Wisconsin, Madison, WI

Registrants will be offered the choice of 22 individual small group workshops. They will also have the opportunity to select from three specialized workshops related to the principles of adult education and the implementation of individualized learning for the adult learner: (1) "Continuing Medical Education Information: Where to Find It and How to Use It"; (2) "Self-Paced Computerized CME via AMA/NET" and (3) "Hospital Cost-Effectiveness Evaluation Network: Project in Economic Grand Rounds."

A select panel will discuss "Fulfilling the Educational Needs of the Individual Physician from the Community Hospital and the University Center Perspective," as one of the final activities of this two-day learning experience.

The ICCME Congress will be held simultaneously with the Fifth Annual Accreditation Council on Continuing Medical Education/State Conference.

The ACCME will convene with invited representatives of state medical societies on Thursday, October 10, 1985 at the Arlington Park Hilton, Arlington Heights, IL.

For additional Congress information, please contact the ICCME, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602 or (312) 236-6110, Ext. 1181. ACCME information can be obtained by contacting P.O. Box 245, Lake Bluff, IL 60044 or (312) 295-1490.

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Ten Years' Experience

Open Heart Surgery in a Community Hospital

By A. Hassan Khazei, M.D., H. Jae Ihm, M.D., Mahmood Fard, M.D., Jackie Marvin, C.C.P., Joong H. Choh, M.D., Erwin Robin, M.D./Elgin

Experience with 1000 cases of open heart surgery at a community hospital is presented. These included 821 patients who underwent coronary bypass procedures electively. The overall hospital mortality for this group was 1.5%. There were 99 patients requiring aortic or mitral valve surgery alone or in combination with other procedures. Overall mortality of this group was 7.2%. Of 177 patients who had aortocoronary bypass surgery and were followed for six years, 152 were alive at the end of this period; 82% reported relief of angina.

Feasibility with respect to need, safety and cost effectiveness is discussed, and, based on our experience, conclusions are drawn that are somewhat in contrast with those of regulatory agencies.

Eight years ago we reported on the feasibility of open-heart surgery in a community hospital and related our experience with the first 100 patients.[1] The purpose of this article is to present our follow-up experience of 1000 cases performed from March 1972 to April 1981. A six-year follow-up of patients who underwent coronary bypass is reported with detail on early and late mortality, relief of angina, smoking habits, and return to employment or customary activity. Finally, guidelines from various agencies in regard to minimal standards for open-heart surgery in other than university or teaching hospitals are discussed.

Clinical Material

From the inception of this program in March 1972 to mid-April, 1981, a total of 1000 cases were performed. There were 821 isolated and combined coronary bypasses, 99 isolated and combined valve surgeries, 29 congenital, and 25 miscellaneous procedures requiring cardiopulmonary bypass.

Coronary bypass operations were divided into Groups A and B. Group A included 821 elective isolated coronary artery bypass graftings (42 single, 176 double, 300 triple, 254 quadruple, 47 quintuple and 2 sextuple) with normal (261) or abnormal (562) left ventricular function. Abnormal left ventricular function was defined as cases fulfilling at least two of three critera: an end-diastolic pressure of 15mmHg to 44mmHg, an ejection fraction of 22%-48%, and a cardiologist's angiographic description of moderate to severe left ventricular hypokinesia or dyskinesia.

Group B consisted of 26 emergency bypasses. The majority of these patients were in cardiogenic shock and had an intra-aortic balloon inserted either before or after surgery. Patients with unstable angina and otherwise stable vital signs requiring semi-urgent surgery were included in Group A.

Of the 99 patients requiring valve surgery, 59 had isolated aortic or mitral valve replacements, while 24 had combined valve replacement and coronary bypass procedures. In addition, there were four double valve replacements and 12 mitral valvuloplasties or commissurotomies. There were 29 congenital cases and 25 miscellaneous cases requiring cardiopulmonary bypass. A description of physical facilities and supportive diagnostic and laboratory equipment was presented in an earlier report.[1]

Angina or myocardial infarction in addition to significant coronary artery stenosis have been primary indications for coronary bypass surgery. The New York Heart Association classifications for coronary bypass surgery were: Class I, 31 patients (4%); Class II, 113 patients

(13%); Class III, 477 patients (56%); Class IV, 226 patients (27%).

Average charges, including all professional fees, were $2053.22 for cardiac catheterization and $6,796.36 for cardiac surgery in 1972. These charges were $4,548.63 and $16,672.51 respectively in 1983. Case load during the year consisted of 743 catheterization and 204 open heart surgeries.

Long-term follow-up consisted of 177 consecutive patients who had aortocoronary bypass from 1972 to 1976 and were followed for an average of five years, a median of four years, and a range of three to seven years.

Results

The operative mortality rate for Group A aortocoronary bypass patients was 1.5% (13 deaths in 821 patients). For Group B it was 15% (4 deaths in 26 patients). In the entire population of patients with valvular surgery there were nine deaths. These included three deaths in isolated and three in combined valve replacement with an overall mortality of 7.2%. Additionally, there were three deaths in the group of multiple valve surgery and/or valvuloplasty. There were 201 early and late complications in 185 patients.

Postoperative myocardial infarction was by far the most common complication. Its occurrence was confirmed by the presence of new Q waves in the ECG, by elevation or specific cardiac enzymes, and/or through isotopic determinations (4.6%).

Other notable morbidity consisted of: re-exploration for bleeding (1.8%); respiratory failure (1.9%); pneumothorax (1.6%); postpericardiotomy syndrome (1.5%); minor reversible brachial nerve palsey (1.3%); wound infection (1.2%); sternal dehiscence (0.9%); air embolism with residual neurological defect (0.1%); and a few rare occurrences of systemic complication (5.2%).

Long Term Follow-Up

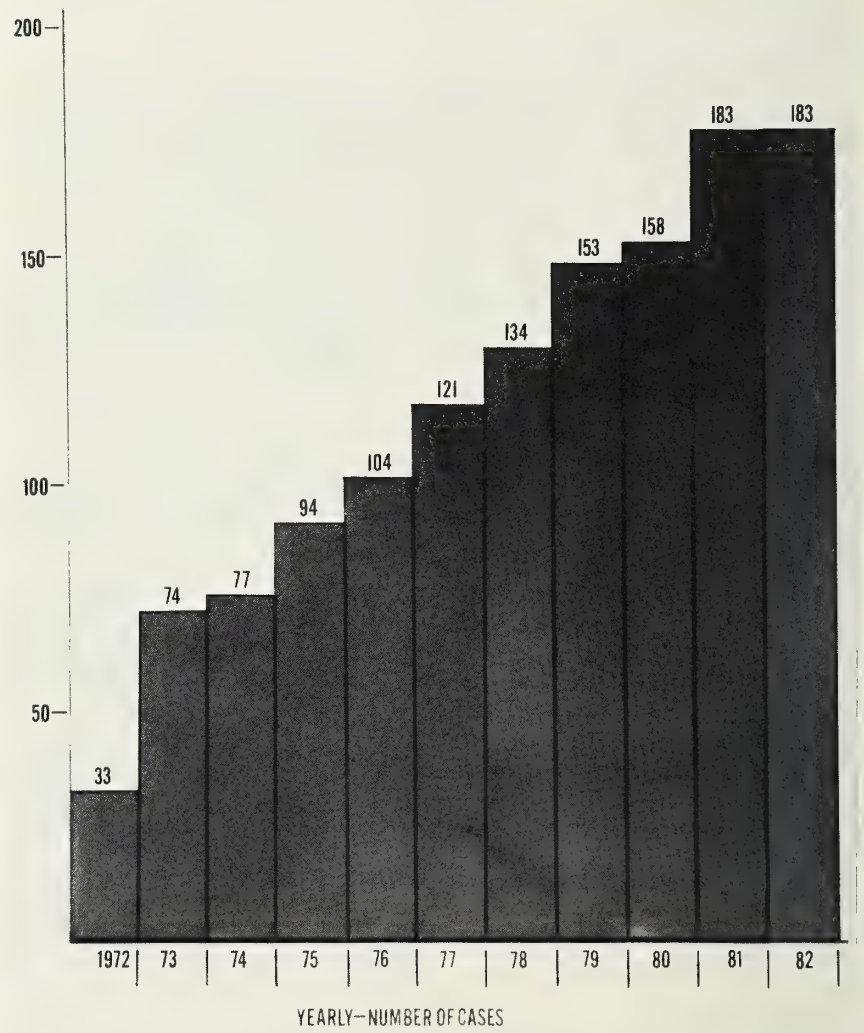
During the period 1972-1978, long term follow-up was conducted in 177 successive aortocoronary bypass patients. The period of follow-up ranged from three years for the most recent cases to seven years for the earliest. A total of 98% (163) of these patients reported angina.

Short and long-term mortality consisted of 25 patients; 152 or 85% were alive at the end of this period. Among surviving patients, 16 (10%) had postoperative angina of about the same degree, 12 (8%) had minimal chest discomfort, and 124 (82%) were free of chest discomfort. One hundred seventy-three (98%) of these patients were smokers preoperatively and nearly all stopped smoking for four weeks prior to the operation; 29 (19%) admitted to having resumed smoking postoperatively. A total of 114 (75%) patients returned to full or part-time employment; nine (6%) filed for disability; and 28 (18%) retired.

Discussion

The results of our surgical treatment of cardiac valvular disease compared favorably with the experience of Teply, *et al.*,[2] (operative mortality of 9.9%) and Copeland, *et al.*,[3] (operative mortality of 7.6%). The experience with short-term coronary artery bypass surgery is quite similar to the Collaborative Study in Coronary Artery Surgery (CASS).[4] The long-term follow-up differs slightly in five year survival with the series reported recently by Guvendik[5] due perhaps to the selection of population. Overall, short- and long-term results compare

Figure 1



favorably both to other community and to teaching hospitals and appear acceptable by present standards.

The point at which a hospital should embark on such an undertaking has been controversial. Guidelines were first suggested by various medical societies and organizations.[6–9] Standards were then established by the federal government. These had been implemented through health systems agencies beginning in 1977.[10] This regulatory/planning effort was designed to prevent duplication, halt or slow cost increases, and safeguard the quality of care. However, determination of the appropriate number of annual cardiac catheterizations and open-heart surgeries appears to be a most difficult and controversial process, bringing about a good deal of discussion.

Aside from the basic requirements,[11] program feasibility will depend on three major factors: need, safety, and cost effectiveness.

A regional medical center with a wide service area and no competing program nearby is justified in providing these services to their area patients. A small hospital in close proximity to an institution providing open heart surgery, however, will do better not to consider it. Where should the line be drawn?

A study by Kennedy found that a total approximate population of 310,000 persons of all ages appeared to provide sufficient volume for adult open heart surgery.[12] In our region, however, after ten years' practice in a service area of about 375,000, the total annual number of open heart surgeries had not reached the required 200 cases by 1981, despite a steady annual growth (Figure 1).

Some have suggested that an open heart surgery unit in a specific smaller community might be justifiable where certain geographic or demographic patterns exist and quality is not compromised.[13] But, in the words of Osler, the environment of a large city is not essential to the growth of a good clinical physician.[14] Safety of a given operation is based on many variables, including the competency of the medical, surgical and supporting nursing staff in a particular area of expertise.

Successful outcome is further influenced by performance of a certain number of procedures per year. A relationship between higher surgical volume and successful outcome for all open-heart surgery has been identified and is certainly justified.[15] However, based on our experience, a case volume may be smaller than 200 cases per year without compromising safety. Safety can be enhanced by designating a director of the program who will be responsible and accountable for the overall satisfactory performance of the team and who will provide detailed guidelines.

McGregor and Pelletier suggested that cost effectiveness will not be achieved until 100 open heart surgeries per year are perfomed.[16] Our experience differs. At the onset of the program, when the case load was scarce, charges were comparatively low (Figure 1). Eleven years later, the hospital charges, including all professional fees, have remained the same despite larger volume. (Charges seen in 1983 are quite similar to 1972 when inflation effect is adjusted).

Based on our experience, we have concluded that this program has been quite cost effective despite a smaller volume, and that the increase in the cost of cardiac catheterization and surgery during 10 years was due solely to inflation. We believe that the recommended 200 cases per year of open heart surgery is an arbitrary case load, not based on practical experience. A lower case load in our institution did not compromise safety and cost. ◀

Erwin Robin, M.D., is a board certified internist with subspecialty certification in cardiovascular disease affiliated with Sherman and St. Joseph hospitals in Elgin, Suburban Medical Center in Schaumburg, Good Shepherd Hospital in Barrington and the Northern Illinois Medical Center, McHenry. Dr. Robin is a fellow of the American College of Physicians, American College of Cardiology, American College of Chest Physicians, American College of Angiology and American Heart Association.

Joong H. Choh, M.D., is a board certified general and thoracic surgeon affiliated with Sherman and St. Joseph hospitals in Elgin and the Northern Illinois Medical Center, McHenry. Dr. Choh is a fellow of the American College of Cardiology, American College of Chest Physicians and American College of Surgeons.

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Mahmood Fard, M.D., is the chief of medicine at St. Joseph Hospital, Elgin and senior cardiologist for Sherman Hospital in that city.

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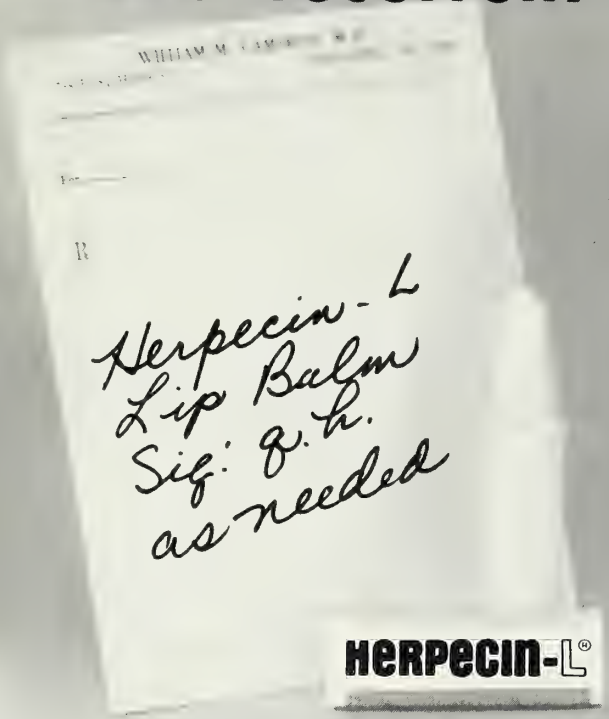
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Zinc Deficiency During Parenteral Hyperalimentation

By Evonne Winston, M.D., Milwaukee, Wisconsin, Denise Rubenstein, M.D., Chicago, John R. Hamill, Jr., M.D., Hudson, Florida and David F. Fretzin, M.D., Chicago

Zinc deficiency, whether arising on the basis of malnutrition,[1] genetic disorders of zinc metabolism,[2] or parenteral hyperalimentation[3] has been associated with features of acrodermatitis enteropathica (AE). While the addition of zinc supplements to hyperalimentation formulations has reduced the prevalence of this disorder, occasional patients maintained on zinc supplemented hyperalimentation have been reported.[4] We describe a case of acquired AE in a patient with granulomatous colitis treated with zinc supplemented total parenteral nutrition. The consequences of zinc deficiency during hyperalimentation and the role of adequate zinc replacement are discussed.

Case Report

A 44 year old black man was in good health until 1977 when he developed granulomatous colitis. He was treated with prednisone and sulfasalazine and did well until 1981 when he developed diarrhea, weight loss and progressive abdominal discomfort. Examination at that time revealed a tender mass in the right lower quadrant and he was admitted for further evaluation. Colonoscopy showed diffuse inflammation of the colon and terminal ileum and numerous pseudopolyps. Multiple biopsies of pseudopolyps demonstrated acute and chronic inflammatory changes without evidence of malignancy. Two enterocecal fistulas were noted on Xray.

During the first two weeks of hospitalization, treatment consisted of prednisone 20mg twice a day, sulfasalazine 1gm three times a day, and a liquid diet. Failure to improve resulted in the initiation of total parenteral hyperalimentation consisting of dextrose, crystalline amino acids, intralipid, and weekly supplementation with intravenous zinc (3mg) and copper (1mg). On this regimen the patient gained weight and the abdominal mass decreased in size; but abdominal pain and diarrhea persisted. During this period the patient was irritable and increasingly dysphoric. On the 28th day of total parenteral feeding, he complained of a sore throat and mouth. Cultures of lesions on the buccal mucosa grew candida albicans, and oral nystatin was administered. In spite of therapy, oral pain persisted.

On the 35th day of hyperalimentation, erythematous scaling, tender lesions appeared around the eyes, mouth and on the scrotum (Fig. 1). A diagnosis of seborrheic dermatitis was made, complicated by secondary candidal infection of the scrotum. One percent hydrocortisone cream was applied to the face and nystatin cream to the scrotum. The facial lesions became crusted and spread to involve the eyelids and nasolabial folds. Shallow, weeping erosions appeared perianally and on the scrotum.

A punch biopsy of a facial lesion was obtained which demonstrated hyperkeratosis, confluent parakera-



Figure 1
Appearance of patient on 35th day of hyperalimentation showing periorbital, nasolabial and perioral eruption.

tosis, modest acanthosis with occasional vacuolated and dyskeratotic cells in the epidermis and a mononuclear perivascular infiltrate in the superficial dermis (Fig. 2). These features suggested a nutritional deficiency dermatitis. A plasma zinc level was drawn, using an appropriate technique to avoid contamination and found to be 31mg/dl (normal 50-150 mg/dl).

In view of the dermatopathologic findings and the low serum zinc level, parenteral zinc supplementation was increased to 15mg/dl daily. The skin lesions improved dramatically within 72 hours with healing of erosions and fading of erythema. The patient's mood markedly improved over the same period. Abdominal pain persisted, however, and ultimately a right transverse colectomy was performed. Postoperative recovery was uneventful.

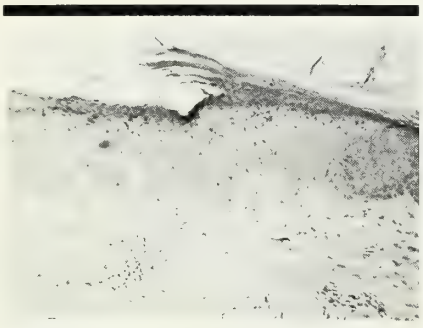


Figure 2
Biopsy of facial lesions showing pale epidermis with confluent parakeratosis and vacuolated and dyskeratotic cells.

Discussion

Zinc has long been recognized as a vital trace element. It is a cofactor in at least 100 essential enzymatic reactions[5] and structurally stabilizes both RNA and DNA.[6] It is not surprising, therefor, that zinc deficiency has been associated with many signs and symptoms including congenital abnormalities, growth retardation, impaired wound healing, gastrointestinal disorders, neurologic dysfunction, and striking dermatologic changes. Due to the essential biologic role of zinc, deficiency in the adult usually manifests at an early stage in tissue undergoing rapid proliferation. The skin provides an early and prominent target for acquired zinc deficiency due to its rapid and continual cell renewal.

Acrodermatitis enteropathica is characterized by perioral, perianal, intergluteal and acral erosions, vesicles or pustules. The elbows and knees may be affected symmetrically. In later stages, keratotic plaques develop. The hair often becomes brittle and sparse and the nails may become dystrophic.

In its early stages AE may be mistaken for seborrheic dermatitis, while older lesions often resemble psoriasis. Secondary yeast or bacterial infection may complicate the clinical picture and obscure the diagnosis. Skin biopsy reveals a psoriasiform dermatitis characterized by a pale appearing epidermal hyperplasia, confluent parakeratosis, scattered dyskeratosis, tortuous papillary capillaries and a modest superficial lympho-histiocytic perivascular infiltrate.[7] These pathologic findings are indicative, although not pathognomonic, of zinc deficiency.

Other clinical features which may occur in AE are diarrhea, anorexia, and neuropsychiatric symptoms including depression and irritability. As reflected in our case, these symptoms may be overlooked in a patient with a complex medical disorder receiving parenteral hyperalimentation. A high level of suspicion and awareness of the potential for zinc deficiency to occur in patients on hyperalimentation will permit early diagnosis. Once the diagnosis is considered, determination of serum zinc levels (avoiding zinc contamination from rubber stoppered tubes and syringe seals) may clarify the clinical picture. Confirmation of the diagnosis is based on the rapid reversal of symptoms and signs following adequate zinc supplementation.

In our patient, initial zinc supplementation was underestimated. The oral daily adult requirement for zinc is 15mg, of which only 10-20% is absorbed. Absorption occurs mainly in the small bowel; intestinal malabsorbtion states predispose to deficiency. Stress has been shown to diminish serum levels of zinc[8] and is an important factor to consider in planning adequate replacement. In addition, anabolic states such as occur during recovery from a major illness may be associated with zinc requirements in excess of the usual maintainence levels.[9] Studies of patients with bowel disease have suggested increased urinary and fecal excretion of zinc. Augmented supplementation may be required in these conditions; 20mg per day of parenteral zinc is recommended. Even when zinc supplementation is instituted in the course of prolonged hyperalimentation, calculated needs may be inadequate. It is advisable for patients on prolonged hyperalimentation to have sequential determinations of serum zinc as a guide to adequate replacement. Clinicians caring for such patients should be aware of the risk of zinc deficiency and cognizant of its clinical expression. ◀

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Opening the Door to Reform

Alfred J. Clementi, M.D., a board certified surgeon, is chairman of the Illinois State Medical Society Board of Trustees. Since Dr. Clementi's term as chairman began in June of 1984, he has been a key leader in the conception and implementation of the society's professional liability initiative. He brought to this job his experience as a chairman of the ISMS ad hoc Committee on Loss Prevention Education as well as a member of the Board of Directors of Illinois State Medical Insurance Services, Inc., the administrative arm of the Illinois State Medical Inter-Insurance Exchange.

We asked Dr. Clementi for a retrospective on the initiative, as well as comments about its implementation.

IMJ: ***You've been involved with the malpractice reform effort from its inception. Now that the legislature is adjourned and the Governor has signed the bill into law, how would you assess the success of physician efforts?***

Dr. Clementi: I think the physicians of Illinois should be very satisfied with the results of their work. They were able to influence the legislature and to persuade their friends to influence the legislature, to bring about genuine reforms. In our opinion, those reforms will greatly impact the frequency of malpractice claims.

But, there is still a great problem with the size of awards. That problem will have to be addressed at some time in the future. I think there are really two ways of doing that. One is by obtaining more malpractice legislation in the future. A second is something we could be doing now—better informing the public about the malpractice problem. After all, it's members of the general public that sit on juries, and they should better understand that the astronomical malpractice awards are coming out of their pockets through higher medical costs.



IMJ: ***We're talking about a public education program?***

Dr. Clementi: Yes. Public education—done by physicians on an ongoing basis—very much like what we encouraged physicians to do in the development and passage of the legislation. Physicians talking to their patients, talking to their friends, continuing with the action teams. We need to educate the public about what the size of the awards is doing to malpractice premiums and other medical costs. Public education on the unfairness of the size of awards in today's courts, and its effect on the quality of care and availability of care, is the major issue.

IMJ: ***You're suggesting that the action teams expand the scope of their work to focus on patient communication?***

Dr. Clementi: I would say the action teams should continue the education process. We have found that physicians have felt very positive about their work in the action teams. They were able to become involved and not only educate themselves, but educate others. The intensity and productivity of these action teams helped them become more comfortable in talking about

the subject. Discussing malpractice is not something that doctors like to do. As they start talking about it, they realize that discussing it is very helpful in accomplishing this goal. That relates to something we've started working on—helping the public understand the impact of these huge awards.

IMJ: *The Illinois news media generally supported malpractice reform. They expressed problems with parts of the legislative package, but overall, physicians feel they received a fair shake. What do you think persuaded the media?*

Dr. Clementi: They listened and they believed that what we said was right. We used a simple approach for our message. We had a complex issue which was not quick or easy to present. But with the help of the public relations department of the state medical society, and advice from a public relations firm, we were able to organize a program. If what you say is right, and the people understand it, the two will come together and bring results.

The media will respond. They'll tell you when they think something isn't quite right. They're willing to listen in most cases. It's an ongoing process for physicians to learn not to be afraid of the media. They have to be able to express their opinions because many times that's the only way for the public to hear what the real problem is.

IMJ: *Is media relations, then, a proper role for the action teams?*

Dr. Clementi: Yes, the action teams must continue to become more aware and familiar with the whole media process. The difficulty is that members of the media have conflicting ideas presented to them. As a result they have to try and pick and choose to determine what is going to get on tonight's television news. There's a certain problem with the selection process. As a result, selection of key ideas through the medical society is very helpful. Whether or not action teams in individual areas can do this is difficult to tell. It may be so in smaller communities with community newspapers. But in larger metropolitan areas, better organization is needed.

IMJ: *How much do you think patients had to do with passage of this legislation?*

Dr. Clementi: We have patients who are very aware of what's going on. And I know they wrote their legislators because we heard through the lobbyists of several letters from individual voters. We must take advantage of their interest to present our ideas. Patients were involved in this process. It's amazing how many people have come into my office saying that they had seen me on television or heard me on a particular radio station and that what I said was right. They really approved of these particular activities. They felt it was about time that some of these changes were made.

IMJ: *Are there specific points for public education that you think the action teams should focus on?*

Dr. Clementi: The major factors have to do with awareness of what the costs are. The example I used on several occasions during the professional liability initiative activities is a malpractice case where a loss of extremity occurs. Such awards in malpractice cases average in the range of $400,000. But in automobile accidents or other liability cases, those size injury awards are $100,000. The larger amount is awarded because it's malpractice—the same injury, the same loss. That's not right, but without a cap on noneconomic loss, only the juries can control that cost. People have to be aware that we don't punish differently because it appears that there's more money available. You give that particular award because you think that's the



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right thing to do. That's really what the jurors need to understand. There is a right award. It's given not because you feel sorry for somebody, but because it was the right thing to do.

IMJ: *We saw a lot of new faces at the Springfield rally. How much has ISMS achieved in the way of bringing doctors together in general?*



Dr. Clementi: I think it was significant. Doctors who had not been involved in the past felt that there was something they could do. They went to Springfield skeptical of accomplishing much and came away with a new feeling that they could make a difference.

We encountered an attitude that the lawyers had everything all set up in Springfield. A lot of people believed that because so many of the legislators are lawyers, they were not going to vote with us. That attitude was crushed. Not only did lawyers in the legislature work with us, but other people who had negative attitudes toward our package changed their positions. And I think it was because of the physicians' impact. Doctors realized that legislators were human beings; they could talk to and influence them with the proper exposure. It was very positive. Physicians learned that they could really accomplish something by being involved.

IMJ: *How much difference do you think the Springfield rally made?*

Dr. Clementi: It was what turned the key—it opened the door to reform.

IMJ: *There were 4,000 doctors in Springfield that day. Were you surprised by the turnout?*

Dr. Clementi: I must say that knowing the doctors and their attitudes, I was not. I knew how the doctors felt about the malpractice problem. I knew they had the commitment and it was just a matter of giving them a chance to do something about it. I really was pleased, but I was not that surprised.

Malpractice has nothing to do with bad medicine. Good doctors have been sued for malpractice. Good doctors have been involved in injuries even though they have done things appropriately.

IMJ: *During the ISMS malpractice initiative, some media reports gave the impression that poor medicine and poor medical discipline really caused the malpractice crisis. What about that assertion?*

Dr. Clementi: Malpractice has nothing to do with bad medicine. Good doctors have been sued for malpractice. Good doctors have been involved in injuries even though they have done things appropriately.

As you say, it was suggested several times during the initiative that if we just got rid of bad doctors, the problem would go away. But there would still be liability situations. We know they exist. There are honest errors that occur even with good physicians. There were also too many nonmeritorious suits.

IMJ: *What would you like to see happen in the area of medical discipline?*

Dr. Clementi: Disciplining professionals is always difficult, because with professionals, we're dealing with judgment. In fairness, discipline requires that those who are in the profession must cooperate. All professionals have the same problem. We would like to see all professionals come together to develop some kind of a professional disciplinary law or professional disciplinary system.

The Medical Disciplinary Board, as it exists now, can be improved. But there will still be challenges against it. I personally think that we need to look at the whole system of discipline, not just from the area of medicine, but from what changes we can make in the law that would affect all groups of professionals. It would help to rehabilitate those who can be rehabilitated, and to remove those who need to be removed from the professional circle.

IMJ: *Isn't passage of the new legislation only the first step? What about its implementation and enforcement?*

Dr. Clementi: Well, I think that Dr. Harold Jensen's comment in his President's Page in *Chicago Medicine* was a very appropriate one. He wrote that while we should be proud of our victory in this battle, the war isn't over yet.

Implementation is a long road. For example, we must ensure that the screening panels are effective, that they do what we had hoped they would do, and that they are well structured. They should not delay justice and they should be fair.

Challenges in the legal system must be rebuffed. It's a continuous battle. We know what happened in 1975 when much of the legislation was overturned. So we know that after passing the legislation there is much still to be done.

IMJ: *Can we talk some more about the medical review panels created by the new legislation and how they would function?*

Dr. Clementi: We believe that the panels will work, but only if the medical and legal professions take them seriously. The Illinois Supreme Court is responsible for developing the rules and regulations that will guide the formation and actions of the screening panels. The Court will also determine the time table for formation of the panels. The Illinois State Medical Society stands ready to cooperate when requested. We'll be working with county medical societies and hospital medical staffs to recruit panelists. We want to be sure physicians do their part.

IMJ: *Some of the malpractice-related legislation passed this session provides immunity for hospital medical peer review proceedings. We understand that under that bill, physicians whose privileges are suspended, limited or revoked couldn't sue the peer review committee or hospital. They do have the option to seek a court injunction if there was an error in the proceedings. How important could this legislation be to effective peer review?*

Dr. Clementi: It certainly is going to lessen the fears that physicians on peer review committees have had in the past. Fears such as: "Can I be totally honest? Can I make an honest judgment without the fear of an actual liability claim against me?"

We also know that some claims provoke personal animosities between physicians who are being reviewed and those who are on the review committee. And these animosities should be avoided. Removing the individual liability could make a great advance in making a judgment. The reviewer should not have to be concerned about whether or not he will be sued in the future by this particular physician.

Of course, there is always the fear that a group of physicians on a particular review committee could be trying to get rid of a doctor unfairly. But the fact is that as long as the physician is able to exonerate himself—and transmit that information to those who are aware that he was under review—I think that addresses the problem. It puts responsibility on the physician to be honest with the hospital staff.

IMJ: *Accompanying changes in malpractice law, have you also thought about change in loss prevention education programs?*

Dr. Clementi: Yes. Loss prevention education programs will continue not only through medical society activities but also through the Exchange. We are thinking about designing some form of correspondence education programs. Videotapes or printed material would enable physicians who have not been able to attend a program to participate and update themselves in loss prevention education.

I would say to expect a continuation of our present program with some modernization, so to speak, and an extension into new areas that we have not previously approached. As you may be aware, the Physicians Insurers Association of America—a nationwide organization of doctor-owned malpractice companies—has an ongoing review of loss prevention education activities. Over the last five years, we've had the opportunity to share some of our ideas with them and learn from them.

IMJ: *Do you think the new law will mean lower malpractice insurance premiums?*

Dr. Clementi: I think it will mean a *stabilization* of malpractice premiums. Not too many things come down in price. But I think if we can

We encountered an attitude that the lawyers had everything all set up in Springfield. A lot of people believed that because so many of the legislators are lawyers, they were not going to vote with us. That attitude was crushed.



stabilize the malpractice premiums, we will have accomplished quite a bit. They were escalating at an uncontrollable rate; if we were to take the 30% increase this year and project it for the next three years, we'd be talking about close to a 100% increase in premiums. That would be just intolerable for doctors' practices. Physicians' incomes are not increasing at anywhere near that rate, and physicians cannot simply increase their fees to cover increasing malpractice costs.

You can't charge Medicaid patients any more, because reimbursement is fixed. Medicare reimbursement is also frozen. If you're in an HMO, you've agreed to a certain fee in that particular area. A smaller and smaller group of people are covered by private insurance and pay for part of their medical care. We can't pile that kind of an increase on those individuals because it would be unjust. The physician is very worried about this kind of escalation. It is destroying medical practice as we want it to be.

ward with some positive responses, rather than simply challenging everything and trying to destroy the improvements in the law. I would hope they would first look at the intent of what these laws are trying to do. These reforms are not trying to block legitimate liability cases. They are trying to expedite their disposition, to make the process more appropriate and more fair. They are trying to avoid redundancies, and excesses in the law, and that's what changes in the law are all about. If they are responsible people, they will come forward with positive malpractice reform on a continuing basis.

caps on the noneconomic portions of malpractice awards. We would also have the benefit of an additional two years' experience in other states to see what advantages caps may have offered in those particular states. The important thing is that we will have two years' experience before we make any decisions about 1987.

There has always been a degree of respect between the medical and legal communities. There's also been a degree of competition.

These reforms are not trying to block legitimate liability cases. They are trying to expedite their disposition, to make the process more appropriate and more fair. They are trying to avoid redundancies, and excesses in the law, and that's what changes in the law are all about.



IMJ: *With respect to the success of the physicians' initiative, do you have the feeling that the legal community was caught napping?*

Dr. Clementi: I think the legal community believed their cause was right. And that they would win because their cause was right.

I believe the legal community will go back to their drawing boards and look at what these changes are, and evaluate their impact. What I would hope they would do is come for-

IMJ: *What should we be looking for in the future?*

Dr. Clementi: There are a lot of possibilities. I would like to begin with 1986 and say that our activities in 1986 will be designed to respond to court challenges and educate the public as to the seriousness of the problem and the need for control of costs. What's done in 1987 will depend very much upon what 1986 brings.

If any of the laws are overturned that will have to be addressed. If everything stays as it is, we certainly would look to the idea or concept of

IMJ: *How do you think this entire experience will affect the relationship between the medical and legal communities?*

Dr. Clementi: Attorneys are, in effect, advocates. They're advocates for their point of view. The fact that they come to the table advocating something that is different from my point of view doesn't bother me. I respect them as individuals.

I do, however, think that the law had gone out of balance. Some attorneys are taking advantage of

that lack of balance. By the same token, I think once balance is restored, they will work within the confines of those particular laws and be effective, good lawyers.

There has always been a degree of respect between the medical and legal communities. There's also been a degree of competition. They do compete as fellow professionals, but on a very healthy level. I don't really see anything damaging.

IMJ: ***What aspects of the legislative initiative remain unresolved?***

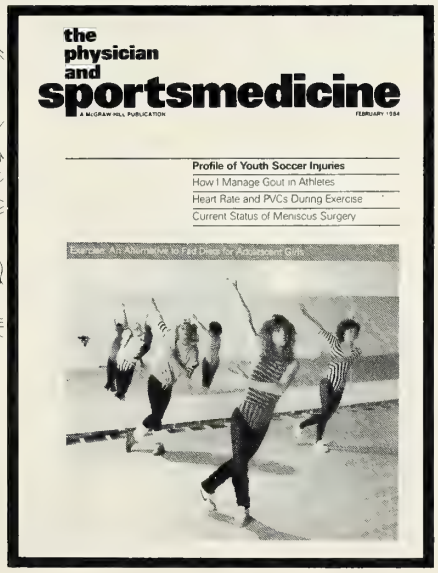
Dr. Clementi: One of the areas that concerns me has to do with the attitude that a doctor may be medically correct but may be indefensible in the courtroom. That has to be examined with a great degree of scrutiny. The reason is that the law has not always allowed for fairness. And we have been told on many occasions that some people may be medically correct but they are not defensible.

There's something wrong with the law when this kind of situation exists. There has to be some change in the way that the evaluation process goes on. Maybe our panels will be able to address it. But it is a great injustice to say somebody has not performed malpractice but may lose the case because he is a poor witness or because he presents poorly to the jury. There is something wrong with the system in this kind of a situation.

I hope that the lawyers will be willing to sit down with us and discuss what changes might be appropriate to make in the future. By that I mean to actually be able to discuss again with the Chicago Bar Association, and the Illinois State Bar Association, what adjustments in the law might be appropriate to further correct these types of inconsistencies.

OVER 66,000 FAMILY PHYSICIANS READ THIS JOURNAL





Practical information on the medical aspects of fitness and exercise.

Tennis elbow: Joint resolution by conservative treatment.

Hypertrophic cardiomyopathy and the athlete.

Effects of sunscreen use during exercise in the heat.

Overuse injuries to the knee in runners.

How I manage ingrown toenails.

MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Severe dementia was evaluated in a community as to race, sex and incidence. The population of one county in Mississippi, including both individuals within a health care program and those without a previous medical record, was tested. Severe dementia was equal in distribution among white and black people. It was present in approximately 1% of the population 40 years of age or older and in 7% of individuals 80 years or older. About 15% of the population refused the examination. The incidence was higher in the female population. (Schoenberg, B., *et al: Arch Neurol* 42#8:740-3, 1985)

Normal individuals perceive a rapid series of afterimages when a bright light briefly strikes the eyes. These series of afterimages were evaluated in a group of patients using a simple pocket flashlight. This flight of changing colors was noted in 95 of 99 normal eyes and was impaired in 45 of 49 eyes with optic neuropathies. In 84 eyes examined by both pattern-reversal visual evoked responses and flight of colors, the results agreed in 87% of cases including those of subclinical optic neuropathies and accurately diagnosed 95% of cases.(Rolak, L.: *Arch Neurol* 42#8:759-60, 1985)

Obesity is clearly associated with hypertension, hypercholesterolemia, non-insulin-dependent diabetes mellitus, certain cancers and such other medical problems as heart disease, chronic obstructive pulmonary disease and arthritides. In infancy and childhood, biologic markers of genetic, metabolic, or anthropometric characteristics may be predictors of adult obesity. Promising leads are the effects of the central and autonomic nervous systems and the endocrine system. Thermogenesis, food intake, satiety factors and cultural factors must be considered in the treatment programs. (Natl Inst Health Consensus Develop Panel on the Health Implic of Obesity: *Ann Int Med* 103#1:147-51, 1985)

Segments of 100 autopsy aortas were examined by light and polarizing microscopy to evaluate the thickness of the adventitial layer, the appearance of the vasa vasorum, the relationship of the intimal atheromatous lesion and its adventitia, and the cellular infiltrate in the outer layer. During the fifth decade a continued increase in the thickness of the adventitial connective tissue was noted with a concomitant thickening in the wall of the vasa vasorum with luminal capacities remaining the same. These changes are believed to be independent of the intimal atherosclerosis. (Greenberg, S.:*Proc Inst Med Chgo*: 38#2:48-9, 1985)

A low intensity negative electric current was applied to ulcers for two hour periods twice daily over saline soaked sterile pads with the dispersive electrodes 15-25cm proximal to the ulcers. The rates of healing of these ulcers were compared to a matched control group. It was found to be 1.5-2.5 times faster with a more resilient scar than the conventional treatment programs and to require fewer debridements. (Carley, P., Wainapel, S.: *Arch Phys Med Rehabil* 66#7:443-46, 1985)

Thiazides are potent inducers of both photoallergic and phototoxic dermatitis. Five cases are reported that exhibited annular or papulosquamous skin lesions with fine scales characteristic of subacute cutaneous lupus erythematosus. The skin lesions rapidly resolved with discontinuance of the medication while anti-SS-A antibodies were still present. (Reed, B., *et al.: Ann Int Med* 103#1:49-51, 1985)

Groundwater samples from 27 counties in Florida close to recognized phosphate ore deposits were evaluated for radiocontamination. In 12.4% of wellwater samples the total radium levels were in excess of 5 pCi/L. Rank correlation coefficients of .56 and .45 were observed between the radium contamination level and the incidence of total leukemia and acute myeloid leukemia, respectively. (Lyman, G., *et al: JAMA* 254#5:621-6, 1985)

Acute dysuria, frequency, or urgency was evaluated in 199 women between the ages of 18-40 years. Infections were retrospectively designated as oral contraceptive related or diaphragm related. Twenty-one percent of 165 diaphragm users developed urinary tract infections compared to 9% using the oral contraceptive method. Partial urethral obstruction due to the placement of the diaphragm may be a predisposing factor as well as changes in the vaginal flora and some sexual habits. Diaphragm users with recurrent urinary tract infections may require altered contraceptive methods and those without infection may obtain some protection from cervicitis and salpingitis that the diaphragm and/or spermicides might provide. (Fihn, S. *et al.: JAMA* 254#2:240-5, 1985) ◀

Listen to the Children

By Suzanne Meirink (Mrs. Thomas) President, ISMSA

"Do ye hear the children weeping, O my brothers,
Ere the sorrow comes with years?"
The Cry of the Children (1844)

Abuse, be it emotional, neglect, sexual or battery occurs hundreds, maybe thousands of times a day in our state and nation. According to a recent article in the *Peoria Journal Star,* (Jan. 31, 1985) the reports in Illinois have increased from 27,000 in 1975 to more than 69,000 in 1983. Shocking? . . . Terrifying? . . . Yes! We can help change these figures around. The answer lies in *education.*

It is important for parents, teachers, and friends to listen to the children. Encourage your children to talk freely to you. If they talk about abuse, seek help. Don't blame them or tease them about it. An American Academy of Child Psychiatry publication, *Facts for Families* (1:9) makes several pertinent suggestions:

- Tell children that if someone tries to touch their body and do things that make them feel funny, they should say "NO" to that person and tell an adult right away.
- Teach children that respect does not mean blind obedience to adults and to authority. For example, don't tell children to, "always do everything the teacher or babysitter tells you to do."
- Encourage professional prevention programs in local school systems.

That same publication lists typical signs of child sexual abuse: (1) unusual interest in or avoidance of all things of a sexual nature; (2) sleep problems or nightmares; (3) depression or withdrawal from friends or family; (4) seductiveness; (5) statements that their bodies are dirty or damaged; (6) refusal to go to school, or delinquency; (7) secretiveness; (8) aspects of sexual molestation in drawings, games, fantasies; (9) unusual aggressiveness; (10) suicidal behavior and (11) other radical behavior changes.

Any of a number of problems may develop as a result of child abuse. These can include a poor self image, a serious drug and/or alcohol problem, failure in academics, inability to depend upon or trust others, aggressive and disruptive behavior, and passive and withdrawn behavior—fear of entering into new relationships or activities. (*Facts for Families* 1:5)

Illinois has addressed the problem of child abuse under the Department of Children and Family Services. Governor Thompson announced in March a proposed program known by the acronym KIDS (Kids in Illinois Deserve Safety). This proposal would increase prison terms for selling babies, and would involve the Department of State Police in the investigation of sexual exploitation. Also, the I-SEARCH program would be expanded. I-SEARCH (Illinois State Enforcement Agencies to Recover Children) is an Illinois Department of Law Enforcement program designed to help the state locate missing children by providing for the sharing of computerized information with surrounding states and some federal agencies. I-SEARCH was developed under the Intergovernmental Missing Child Recovery Act which Governor Thompson signed into law last fall. As with many government programs, they need money to expand and excel. Fifty applications for establishing local I-SEARCH units have been received to date. Local I-SEARCH units are eligible for a 50% matching grant from the Department of Law Enforcement to assist in their program costs. Seventeen grants have been awarded at this writing. The grant money is used for computers and staff. For more information on I-SEARCH, contact Daniel Mascaro, Assistant Deputy Director, I-SEARCH Program Coordinator (217-782-6429).

Prevention and education is the key to solving the problem. Police Lt. Robert Robertson was quoted in the Detroit *Free Press* on the subject:

"This is something we won't be able to handle until the public becomes aware of it and angered by it. Nothing has ever been accomplished until society took a stand—somebody has to get outraged." ◂

DOCTOR'S NEWS

ERRATUM

An error occurred in transcription of last month's *IMJ* interview with Illinois Department of Public Aid Director Gregory L. Coler ("Not Just a Check But a Chance," 168:2, 102-108, August 1985). On page 104 we quoted Director Coler's estimate of the typical time lapse between physician billing and payment of clean claims as three days. His estimate was actually 30 days. The editors apologize for this error.

HOSPITAL LICENSING BOARD ADDRESSES MEDICAL STAFF ISSUES

The Illinois Hospital Licensing Board voted during its August 1 meeting to amend its present rules regarding medical staff composition. The new language more clearly delineates that hospital medical staffs be limited to doctors of medicine, osteopathy, dental surgery, and podiatric medicine. The Board also voted to retain the present definition of "Allied Health Personnel." The Board's actions follow a recommendation by Dr. Bernard Turnock, director of the Illinois Department of Public Health. Before taking effect, the Hospital Licensing Board's recommendation on medical staff composition must be submitted to Dr. Turnock for his approval, published for comment by other interested parties, and submitted to the state's Joint Commission on Administrative Rules.

Taken under advisement by the Board was a new rule regarding due process for medical staff members. The new rule, offered by the Illinois State Medical Society, incorporates ISMS principles regarding the need for due process and the concern that hospitals have the discretion to determine the extent of due process provided to all applicants for medical staff membership as well as for current staff members. ISMS proposed the new rule after the Illinois Attorney General interpreted existing rules to require hospitals to provide full due process rights to *all* applicants for medical staff membership, a situation which could overwhelm hospitals.

RESIDENT STRESS TOPIC OF CONFERENCE

"Stress, Impairment, and the Resident" is the theme of an October 24-26 conference sponsored by the American Medical Association and the University of Illinois at Chicago. The conference, which offers eight hours of Category 1 continuing medical education credit, is to address the "humanistic, ethical, and practical issues of housestaff training and prevention of stress-related disorders." Primary emphasis will be placed on the role of the training environment and innovations which can reduce the incidence of stress. Further information is available from Mary Dybas or Nancy Autrey at the University of Illinois, Chicago; Conferences and Institutes, 912 S. Wood St., Chicago, IL 60612, (312) 996-8025.

MEDIA REACTS TO ISMS WARNING ON SEAT BELTS

Many of the state's newspapers and broadcast outlets reported the Illinois State Medical Society's warning to physicians, suggesting that they use strict medical criteria for granting patients exemptions from the state's new mandatory seat belt law.

Physicians were advised that they could face possible lawsuits by patients injured in motor vehicle crashes while unrestrained. The new law states that mandatory seat belt use does not apply to "a driver or passenger possessing a written statement from a physician that such a person is unable, for medical or physical reasons, to wear a seat safety belt." The statue, however, is silent on any liability for future injury a doctor may assume in absolving a patient's responsibility to buckle up.

AMA HIRES OMBUDSMAN FOR ILLINOIS, OTHER UNIFIED STATES

Following an action of the American Medical Association House of Delegates in December 1984, the AMA has hired a special "ombudsman" to handle inquiries, requests, and complaints from members of state societies who require corresponding AMA membership. All ISMS members are eligible to utilize the services of the ombudsman, Wende L. Corbett. A special "unified member hotline" has been set up with physicians able to call collect at (312) 645-5323.

GET WELL WISHES FOR ISMS MEMBERS

The Illinois State Medical Society has established a mechanism to extend get well wishes to ailing physicians. Persons who are aware of a member who is not well and who might appreciate a greeting from the society are encouraged to advise the division of membership/marketing in the ISMS offices, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602; (312) 782-1654.

PHYSICIANS IN THE NEWS

Harold L. Jensen, M.D., Flossmoor, has assumed the office of president of the Chicago Medical Society (CMS). An internist, Dr. Jensen currently serves as a trustee of the Illinois State Medical Society. He is past president of the medical staff at Ingalls Memorial Hospital in Harvey, where he is director of continuing medical education. He also is on the medical staffs of South Suburban Hospital, Hazel Crest, and the University of Illinois Hospital in Chicago. Dr. Jensen is clinical assistant professor of medicine at the University of Illinois, and has served as chairman and vice-chairman of the Chicago Medical Society Council.

Elected President-Elect for the upcoming year has been **Pedro A. Poma, M.D.,** Melrose Park. Dr. Poma also is a trustee of ISMS, and serves as chairman of the Society's Publications Committee, which oversees production of *IMJ*.

Other CMS officers elected include **Robert M. Vanecko, M.D.,** a Chicago thoracic surgeon, secretary; **Joseph C. Sherrick, M.D.,** a Northbrook pathologist, treasurer; **James H. Andersen, M.D.,** an Oak Brook thoracic surgeon, chairman of the council; and **Ulrich F. Danckers, M.D.,** a River Forest radiologist, vice chairman of the council.

Raymond E. Reich, M.D., Ph.D., Western Springs, has been elected president of the medical staff at Holy Cross Hospital, Chicago. Dr. Reich previously served as chairman of the hospital's department of medicine. Other medical staff officers elected were: **John A. Caserta, M.D.,** Justice, vice president; **Dr. Parakrama de Silva,** Chicago, secretary; and **Juan Ugarte, M.D.,** Chicago, treasurer.

Roque Pifarre, M.D., Oak Brook, chief of the cardiopulmonary surgical section and surgical director of the heart transplant program at Loyola University Medical Center, Maywood, has been chosen Loyola's "Faculty Person of the Year" for 1985. The award is the highest honor a member of the university-wide Loyola faculty can receive. Dr. Pifarre taught surgery at Georgetown University before joining the medical center when it opened in 1969.

The Philippine Medical Association in Chicago (PMAC) has named new officers for 1985-86. **Prisco Olaya, M.D.,** an internist affiliated with St. Anthony Hospital, Central Community Hospital and Holy Cross Hospital in Chicago, has assumed the presidency. Other officers elected are: **Rolando Casis, M.D.,** South Barrington, president-elect; **Benjamin Narrojos, M.D.,** Oak Brook, vice-president; **Virgilio Jonson, M.D.,** Oak Lawn, treasurer; **Rene Pena, M.D.,** Aurora, secretary; and **Cesar Reyes, M.D.,** Downers Grove, executive secretary.

JCAH RECRUITING SURVEYORS

The Joint Commission on Accreditation of Hospitals is recruiting both full-time and part-time physician surveyors for its hospital accreditation program. Qualifications for physician surveyors include: a current medical license; at least 15 years service on a hospital medical staff with committee and leadership responsibilities; extensive clinical and patient care management experience; strong oral and written communication skills; and excellent physical health. Benefits cited by the JCAH include a yearly salary and per diem expenses, noncontributory life insurance, medical insurance, a retirement plan, and an optional, tax-sheltered annuity plan. Interested physicians should send a copy of their curriculum vitae to Kristin V. MacRae; Director of Personnel; JCAH; 875 N. Michigan Ave., Chicago, IL 60611; (312) 642-6061.

TREATMENT OF DD PATIENTS SUBJECT OF SURVEY

The Illinois Association of Rehabilitation Facilities—in cooperation with the Governor's Planning Council on Developmental Disabilities—is surveying all Illinois physicians to determine whether they serve developmentally disabled persons. The results of the survey are to be published in a directory to help disabled persons find physicians whose offices are accessible and who are familiar with specific disabilities. Interested physicians who have not received a survey can contact the association at (217) 753-1190.

SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies

From the Department of Alcoholism and Substance Abuse (DASA)

DASA has begun mailing to all Illinois physicians a cover letter and booklet describing the implementation, new forms and procedures governing the revised Triplicate Prescription Control Program (TPCP). The mailing is being sent to practitioners in a graduated alphabetical fashion over a period of several months.

The TPCP is being revised to provide a modern, computer-based program to serve as an effective deterrent to the misuse, abuse and diversion of Schedule II designated product controlled drugs. While previously used only for law enforcement purposes, the new program has been designated to generate information which can also be used in pain management studies, utilization surveys, educational programs, and practice management.

New features of the TPCP include: having each form preprinted with the physician's name, address and controlled substance license number; permitting generic drug substitutions where deemed appropriate; permitting a physician to get a copy of his or her own prescribing profile; having preprinted expiration dates for forms; and having, as part of a pad, a list of all drugs required to have a triplicate prescription.

New requirements include: having all physicians re-apply for new triplicate forms if they want to prescribe Schedule II designated substances; permitting the use of the old and new forms until February 1986; and increasing the fee to $10.00 for 100 prescription blanks.

A reference booklet describing the application, prescribing and recordkeeping processes for physicians and pharmacists will be sent to each physician along with the general program overview letter.

Anyone having questions about the TPCP should contact the DASA Triplicate Prescription Control Section in Springfield (217/782-0685) or in Chicago (312/917-3840).

(Source: Correspondence from the Manager, Triplicate Prescription Control Section)

From the Department of Public Health (IDPH)

Haemophilus Influenzae Type B Vaccine

The Illinois Department of Public Health, on recommendation of its medical advisors, endorses the recommendations for use of Haemophilus b polysaccharide vaccine contained in the April 19, 1985 issue of the Centers for Disease Control *Morbidity and Mortality Weekly Report.*

These recommendations apply to the use of the vaccine in routine pediatric care as well as in situations of special risk. At the present time, IDPH does not expect to be able to provide the Haemophilus b polysaccharide vaccine.

If there are any questions regarding this vaccine, please contact your regional office of the IDPH, your local health department or the IDPH Communicable Disease Program at 217/782-2016.

(Source: July 15, 1985 memorandum from Director of IDPH to all physicians.)

HTLV-III Antibody Testing

The Medical Determinations Board (the medical advisory body to the director of the department public health) has recommended that IDPH take the following actions regarding the HTLV-III antibody test:

1) Continue to prohibit blood banks from releasing the results of HTLV-III antibody tests, used for screening blood, to donors;
2) Offer the state lab to perform HTLV-III antibody tests for physicians and local health departments which send samples from their patients, as part of a total patient assessment;
3) Expand the state lab to give it the ability to perform the ELISA and the Western blot tests;
4) Initiate extensive educational programs on AIDS and the HTLV-III antibody test for health professionals and the general public; and
5) Request that IDPH apply to the federal government for permission to modify its funding request to permit the above activities.

(Source: July 15, 1985 meeting of Medical Determinations Board)

Ambulatory Surgical Treatment Centers (ASTC)

The ASTC Advisory Board is considering modifying the rules requiring that all x-rays be reviewed by a radiologist and all tissues be reviewed by a pathologist. The proposals would permit any physician, dentist or podiatrist to review x-rays on his ambulatory surgical patients, and would identify specific types of tissues that could be excluded from review.

(Source: July 11, 1985 meeting of ASTC Advisory Board)

From the Department of Registration and Education (DRE)

Disciplinary Actions

- *Ricardo A. Cea* (Lic. #36-45170 & 003-36-45170-1)
 On June 5, 1985, the medical and controlled substance licenses of Dr. Cea were suspended.
- *Ludovico E. Estoye* (Lic. #36-40803)
 On June 5, 1985, the medical license of Dr. Estoye was placed on probation for two years.
- *Avner Kauffman* (Lic.#036-030820)
 On June 28, 1985, the medical license of Dr. Kauffman was placed on probation and his controlled substance license suspended.
- *Reya Mashayeski* (Lic. # 3 036-49583)
 On June 5, 1985, the Director of DRE ordered the medical license of Dr. Mashayeski be indefinitely placed in a non-renewed status.
- *Sinisa Princevac* (Lic. #36-49181)
 On June 5, 1985, the Director of DRE denied the license restoration request of Dr. Princevac.
- *Milton Charles Schell* (Lic. #3 36-19567)
 On June 5, 1985, the medical license of Dr. Schell was placed on a 2-year probation, along with certain conditions.
- *Kirit Solanski* (Lic. # 036-062910 & 003-036-062910)
 On May 23, 1985, the medical and controlled substance licenses of Dr. Solanski were summarily suspended, pending a later hearing.
- *Eugene Tapia* (Lic. # 036-035954 & 003-036-035954)
 On May 23, 1985, the medical and controlled substance licenses of Dr. Tapia were suspended, pending a hearing on the charges.
- *Shoh Kai Tan* (Lic. # 36-36577)
 In May, the medical license of Dr. Tan was restored to full status.
- *Alejandro F. Villegas, Jr.* (Lic. # 36-047136)
 On July 12, 1985, the medical license of Dr. Villegas was suspended.

(Source: Orders received from the Director of DRE)

EKG

(Continued from page 144)

Answers: 1. A 2. A, E

Several electrocardiograms taken during the palpitations showed the same arrhythmia as the first six beats of the figure: paroxysmal supraventricular tachycardia or PSVT best seen on the top strip. In many patients, PSVT is only minimally disturbing. When therapy is required, PSVT often responds to empiric therapy, most often digoxin. In our patient, recurrent attacks of PSVT continued despite various trials of anti-arrhythmic medications including digoxin, quinidine, disopyramide, and propranolol. Verapamil was not successful because of orthostatic hypotension. An electrophysiology study was performed. The PSVT could be induced by single programmed premature atrial stimuli, rapid atrial pacing, and rapid ventricular pacing. The PSVT could be reliably terminated by overdrive atrial pacing with more than three atrial extrastimuli. The PSVT consistently had a rate of 180 beats per minute and was terminated by overdrive pacing at 200 beats per minute. A chronic electrophysiologic study to serially evaluate drug efficacy showed that the PSVT could be induced despite adequate doses of digoxin, propranolol, and procainamide. Quinidine and disopyramide caused unacceptable side effects. The electrophysiologic mechanism of the PSVT was atrioventricular nodal reentry. Since all available drug therapy failed, in November, 1980, an experimental atrial pacemaker was implanted to provide overdrive termination of the PSVT.

The pacemaker system is designed to function as a unipolar demand pacemaker unless the overdriver is employed. The overdriver is a small box with an external magnet which automatically converts the pacemaker unit to a triggered mode. The overdrive then delivers the programmed mode of stimulation to the patient's skin, where it is sensed by the pacemaker and delivered simultaneously to the pacing electrode to terminate the tachycardia. The programmed mode of overdrive atrial stimulation consisted of fifteen paced beats (S_1 to S_{15}) in a burst at a rate of 200 beats per minute. The figure shows a lead II rhythm strip on top with four leads of intracardiac electrograms below. The electrograms in the last three beats are sensing artifacts from the pacemaker. The patient had to be able to initiate the burst pacing sequence by placing the overdriver unit over the skin covering the subcutaneous pacemaker unit. Patients with hemodynamically compromising tachycardia would not be candidates. Other disadvantages of this pacer-overdriver system are the requirements for good skin contact by the overdriver electrodes and normal pacer sensing function. Fortunately, drug resistant PSVT is rare. Programmable tachycardia terminating pacemakers present an option for the treatment of these patients.

For further reading, see Griffin, *et al.*, in Cardiac Arrhythmias, A Decade Of Progress, D.C. Harrison, Ed., Chapter 27, "A Programmable Tachycardia Terminating Pacemaker for the Treatment of Arrhythmia," G. K. Hall Medical Publishers, Boston, 1981.

Viewbox

(Continued from page 129)

Diagnosis: Subcapsular Splenic Hematoma

Each of the alternatives may present as a focal defect in the spleen. However, the characteristic crescentic defect in the setting of trauma makes subcapsular hematoma the most likely option.

Splenic Cyst

Cystic lesions of the spleen are rare. They may be single or multiple, primary (those with a secretory epithelial lining) or secondary (those without such lining). Primary cysts are only one-fifth as common as secondary cysts.[1] Primary cysts may be the result of parasitic infection (usually echinococcus), tumor (dermoid, epidermoid or other benign neoplasm) or congenital causes. Malignant splenic cysts have not been reported. Congenital cysts may arise via infolding of the peritoneum, dilation of normal lymphatics or trapping of peritoneal cells within the spleen as primitive lobes of the spleen fuse to form the complete organ. The more common secondary splenic cyst is usually a sequela of trauma. Trauma to the spleen produces a hematoma or subcapsular bleed. Subsequent lysis of blood leads to a cystic fluid filled space surrounded by a fibrous wall. These cysts are usually solitary and unilocular. Peripheral calcification may occur (Figure 2).

Other rare varieties of secondary cysts include degeneration of an infarct and intrasplenic dissection of a pancreatic pseudocyst. The latter arises as the result of the action of proteolytic enzymatic secretions escaping the inflamed or injured pancreas. Digestion by these enzymes allows the pseudocyst to dissect along soft tissue planes. Since the splenic capsule at the hilus is continuous with the peritoneum that covers the anterior surface of the pancreas, the spleen at this site is an accessible port of entry for an expanding pseudocyst.[2]

Splenic Infarction

An infarct is one of the most common causes of a focal defect on 99mTc Sulfur Colloid liver spleen scans. The defect is usually peripheral and often wedge shaped.[3] The etiology of splenic infarct is diverse and includes emboli from atheromatous plaques, cardiac mural thrombi or vegetations on cardiac valves as the result of endocarditis. Another common etiology for splenic infarction are the hemaglobinopathies, particularly sickle cell disease. Infarction in these disorders is due to vascular blockade by sickled cells. Clinically, these patients present with intense, sharp LUQ pain which may radiate to the left shoulder. A friction rub over the spleen may be present.[4] Myeloproliferative and lymphoproliferative disorders may also result in splenic infarction. Chronic myelogenous leukemis (CML) is the most common leukemic disorder implicated. Up to ⅓ of CML patients have splenic infarction at autopsy. Polycythemia vera and myelofibrosis with myeloid metaplasia also cause infarction due to sequestration of platelets or white cells in the sinusoids of the red pulp or inadequacy of blood supply to the rapidly enlarging spleen. Disseminated intravascular coagulation may also play a role in terminal cases. Myelofibrosis may result in patchy distribution of radiopharmaceutical in the enlarged spleen.[5] Other causes of splenic infarction include Gaucher's disease, pancreatitis, periarteritis nodosa, malignant hypertension, terminal chronic renal failure and amyloid. Caution should be used in interpreting defects on posterior views of liver spleen scans. Wedge shaped defects which mimic infarction can be seen. These actually represent the impression of the left lobe of the liver on the spleen.

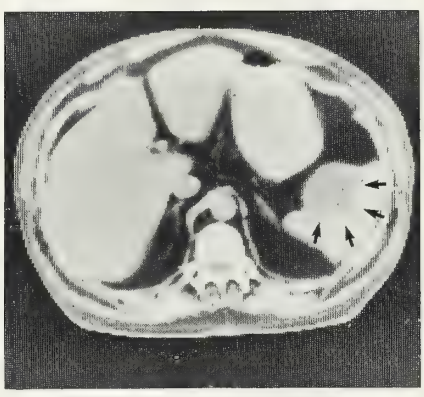


Figure 2
CT scan through upper abdomen. Splenic cyst seen as low density lesion with peripheral rim of calcification (arrows). The patient had a history of abdominal trauma several years prior to the scan.

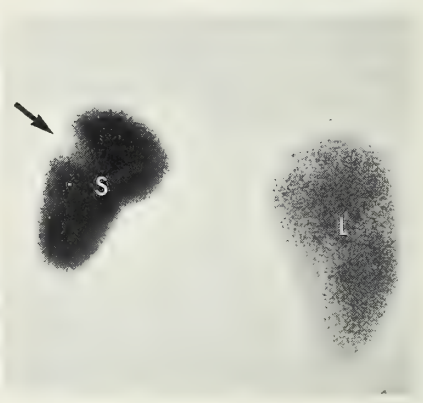


Figure 3
99m Technitium Sulfur Colloid liver spleen scan (L—liver; S—spleen). Posterior view. Splenic infarct shown as wedge shaped defect on the lateral border of the spleen (arrow).

Multiple angulated views or rescanning the patient in a different position will resolve most cases (Figure 4).

Splenic Abscess

Splenic abscess is uncommon; autopsy incidence varies from .14% to .70%. Even in the antibiotic era, mortality is 40-100%. Delay in diagnosis is a significant contributor to this mortality. Practically every organism has been isolated from splenic abscesses except gonococcus. Currently, streptococci and gram negative rods from the gastrointestinal tract are the most frequent agents isolated. Splenic abscesses occur in two distinct clinical settings. The first is as a manifestation of disseminated infection in the compromised host. The prognosis is poor and diagnosis is often made at autopsy. Splenic abscess less commonly presents as a solitary focus of infection. However, it is this setting which is most likely to be diagnosed. The patient has fever and abdominal pain which is frequently in the region of the spleen. The pain may radiate to the left shoulder. Other findings include tender splenomegaly, friction rub over the spleen and leukocytosis. Radiographs are nonspecific and reflect an inflammatory process in the LUQ—elevation of left hemidiaphragm, pleural effusion and displacement of adjacent organs. Liver spleen scintigraphy is 90% accurate in detecting splenic abscesses which show up as single or multiple defects.[6] Multiple abscesses occur in the compromised host. Older series reported typhoid, malaria and dysentery as the most frequent causes, followed closely by intravenous drug abuse. Less common are sources of hematogenous infection in the urinary or gastrointestinal tract and trauma. Infection of a splenic cyst has been reported. Sickle cell disease predisposes to splenic abscess as well as splenic infarction.

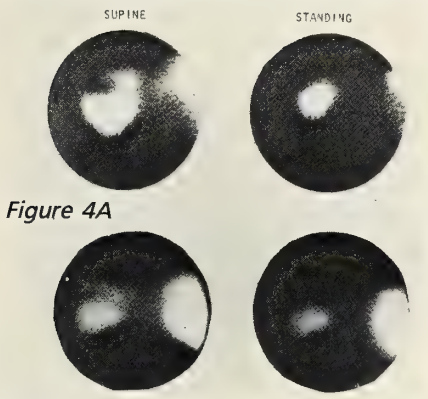


Figure 4A

Figure 4B

Figure 4
False-positive spleen scan. Two cases (A and B) in which defects seen on posterior spleen scan disappeared when scan was repeated with patient in standing position (Illustration from "An artifact that simulates an infarction on a posterior view spleen scan." Letter to the Editor by U. Yun Ryo and reproduced courtesy of the Journal of Nuclear Medicine*).*

Splenic Tumor

Both Hodgkin's and non-Hodgkin's lymphoma frequently involve the spleen. The most specific findings of splenic involvement in the lymphomas are marked splenomegaly and focal defects. Unfortunately, these are relatively insensitive criteria since splenomegaly can be secondary to non-specific reactions to disease elsewhere in the body, the spleen may be involved with lymphoma in the absence of splenomegaly and focal defects are seen in only 10-24% of patients with pathologically proven splenic lymphoma.[7] Metastatic involvement of the spleen, except for hematologic malignancies, is distinctly unusual: 7% at autopsy in patients with underlying primary tumors. Involvement of the spleen usually accompanies carcinomas most frequently with malignant melanoma (30-50%), breast (20%), ovary and lung (9%) primaries. However, since lung and breast carcinomas are more common than melanoma, they account for 40% of all splenic metastasis at autopsy. Occasionally, an isolated splenic metastasis is the initial manifestation of a distant primary such as colon, lung or melanoma. Metastasis can present as splenomegaly or focal defect.[8]

Trauma and Congenital Splenic Fissures

The spleen is the most frequent organ injured by blunt trauma to the abdomen. The patient presents with LUQ tenderness and pain which may be referred to the left shoulder (Kehr's sign). However, these features may not be prominent if there are other injuries. Therefore, evaluation with imaging studies is indicated if the patient has had severe blunt trauma, has a falling hematocrit, radiographic evidence of upper abdominal trauma or unexplained hypotension. Since plain radiographic findings of splenic injury are non-specific and unreliable, the liver spleen scan and CT are the diagnostic procedures of choice.[9]

Findings indicative of splenic injury on liver spleen scans include intrasplenic defects, generalized splenic enlargement with patchy uptake and flattening and concavity or blurring of the lateral splenic border indicative of subcapsular hematoma. Most specific for splenic laceration and fragmentation are multiple linear or stellate shaped defects. Less specific is marked displacement of the spleen away from the diaphragm or lateral body wall.

The overall sensitivity of the liver

spleen scan in the setting of trauma is 97% with a specificity of 96%.[10] Most false positive studies are due to congenital fissures, bipartite spleen, "heart shaped" or "upside down" spleen or other congenital anatomic variants[11] (Figure 5). Other causes of focal splenic defects (tumor, cyst, etc.) may be present but they tend to produce less angular and more spherical defects than trauma. The clinical setting is also helpful in differentiating these conditions. Small subcapsular hematomas may cause too little splenic displacement or distortion to be evident on the scan.

CT is also a highly sensitive and specific method to diagnose splenic trauma. In comparison to liver spleen scanning, CT offers superior resolution of intrasplenic defects, ability to detect retroperitoneal and other associated intra-abdominal injuries and greater sensitivity in the detection of intra-abdominal fluid. However, CT has several disadvantages relative to liver spleen scanning in the setting of trauma. CT requires IV contrast with the small but significant risk of adverse contrast reaction. CT exams cannot be done portably. Patient cooperation is also somewhat more essential in obtaining quality CT images than with liver spleen scanning. The presence of surgical clips in the upper abdomen can seriously degrade the diagnostic quality of the CT scan due to artifacts but not the radionuclide exam. CT is also a more costly examination with greater radiation dose. Finally, isodense subcapsular hematomas may be missed on occasion despite IV contrast.[12]

In recent years, the surgical approach to splenic trauma has changed. Formerly, splenectomy was the procedure of choice for splenic injury. However, the increased risk of post-splenectomy sepsis, even in otherwise healthy patients, has led to a re-evaluation of this therapy. Currently, a nonoperative approach to splenic injury is recommended, provided the patient remains stable and suffers no continued blood loss, has no severe associated injuries or has suffered total avulsion or extensive fragmentation of the spleen. Follow-up scans are then obtained at monthly intervals to document healing, which occurs in 80% by three months. Those with widely diastatic fragments may take up to a year to heal.

The change in surgical management[13] has important implications for the selection of diagnostic procedures in patients with splenic trauma. Many of the causes of false negative and positive liver spleen radionuclide scans do not have clinical significance. Unless the patient destabilizes or meets the criteria described above for immediate surgical intervention, management will be conservative. In this situation, the superior spatial resolution of CT is of less significance since subtle injuries are not likely to prompt a change in the management. Certainly, liver spleen radionuclide scanning is a cheaper and efficient way to follow-up known injuries. Therefore, Berg[12] has recommended that the routine initial diagnostic procedure in suspected splenic injury should be the liver spleen radionuclide scan. CT should be reserved for patients suspected to have associated intra-abdominal injuries which could alter conservative therapy. Liver spleen scintigraphy is recommended for follow-up examination of splenic injury, regardless of the means used to obtain the initial diagnosis. ◀

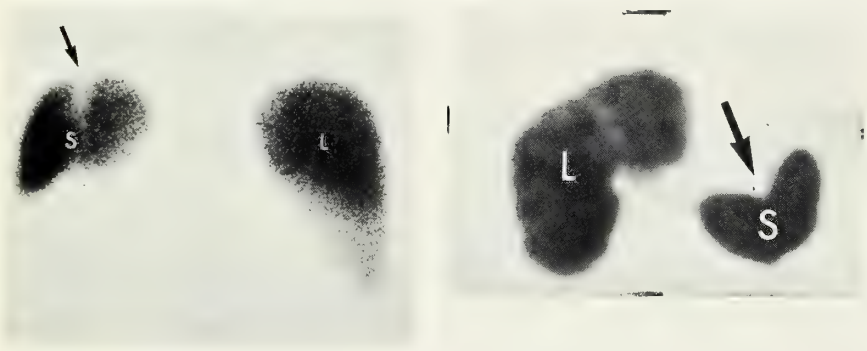


Figure 5
99m Technitium Sulfur Colloid liver spleen scan (L—liver; S—spleen). Figure 5A Posterior view. Note, linear defect through middle of spleen (arrow). Figure 5B SPECT (Single Photon Emission Computed Tomography) transaxial view. SPECT is a nuclear medicine tomogram. The transaxial view (the same plane as CT slices) demonstrates the linear defect on the posterior view, which could have been mistaken for a splenic laceration, actually corresponds to the hilus of the spleen (arrow) which is in an inverted position.

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AAMA National Convention

By Catherine M. Hill, CMA and Robin Bluestein, CMA-C/Palatine and Chicago

The 29th annual convention of the American Association of Medical Assistants (AAMA), will be held September 30th through October 4th in Lexington, Kentucky. The headquarter hotel is the Hyatt Regency with additional accommodations at the Radisson Plaza Hotel.

The theme for this year's convention is, "Focus on the Future." The continuing education unit workshops will include:

- quality control in the office laboratory;
- personnel management: hiring and firing;
- why patients are not compliant;
- evaluation of home health care;
- patient-controlled analgesia;
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- nuclear medicine.

In accordance with the long range plan, this will be the final convention of the AAMA. Five regional conferences will be available to our members throughout the United States. These regional conferences will include educational programs and social activities.

The business portion, normally conducted at the national convention, will be held on a yearly basis in Chicago.

Information regarding the AAMA National Convention, Illinois Society and/or medical assisting can be obtained from Robin Bluestein, CMA-C, co-chairman, Public Relations Committee, 2247 West Estes, #2, Chicago, Illinois 60645 or Catherine M. Hill, CMA, co-chairman, Public Relations Committee, 900 South Plum Grove Road, Palatine, Illinois 60067. ◂

Correction

An error occurred in publication of the new officers as listed in the July issue (168:1, 51, July 1985). The feature showed that A. Ruth Thompson, CMA, vice speaker of the House, was a member of the St. Clair Chapter. Ms. Thompson is a member of the Macon Chapter.

PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

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SORBITRATE®
(ISOSORBIDE DINITRATE)

Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks. Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis.

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites. Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established. If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension.

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE. The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy.

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary.

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur. Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory. The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined. However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals. On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months.

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers. In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal. The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly.

Information for Patients: Headache may occur during initial therapy with SORBITRATE. Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use.

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates.

Isosorbide dinitrate acts directly on vascular smooth muscle; therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug. A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet.

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose. There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman.

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established.

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related. In clinical trials at various doses, the following have been observed.

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent. Cutaneous vasodilation with flushing may occur. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur. Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg; for oral (swallowed) tablets, 5 to 20 mg; and for controlled-release forms, 40 mg.

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose. In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure.

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours. Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported.

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended. The extent to which development of tolerance should modify the dosage program has not been defined. *The oral controlled-release forms of isosorbide dinitrate should not be chewed.*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg); Chewable Tablets (5, 10 mg); Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg).

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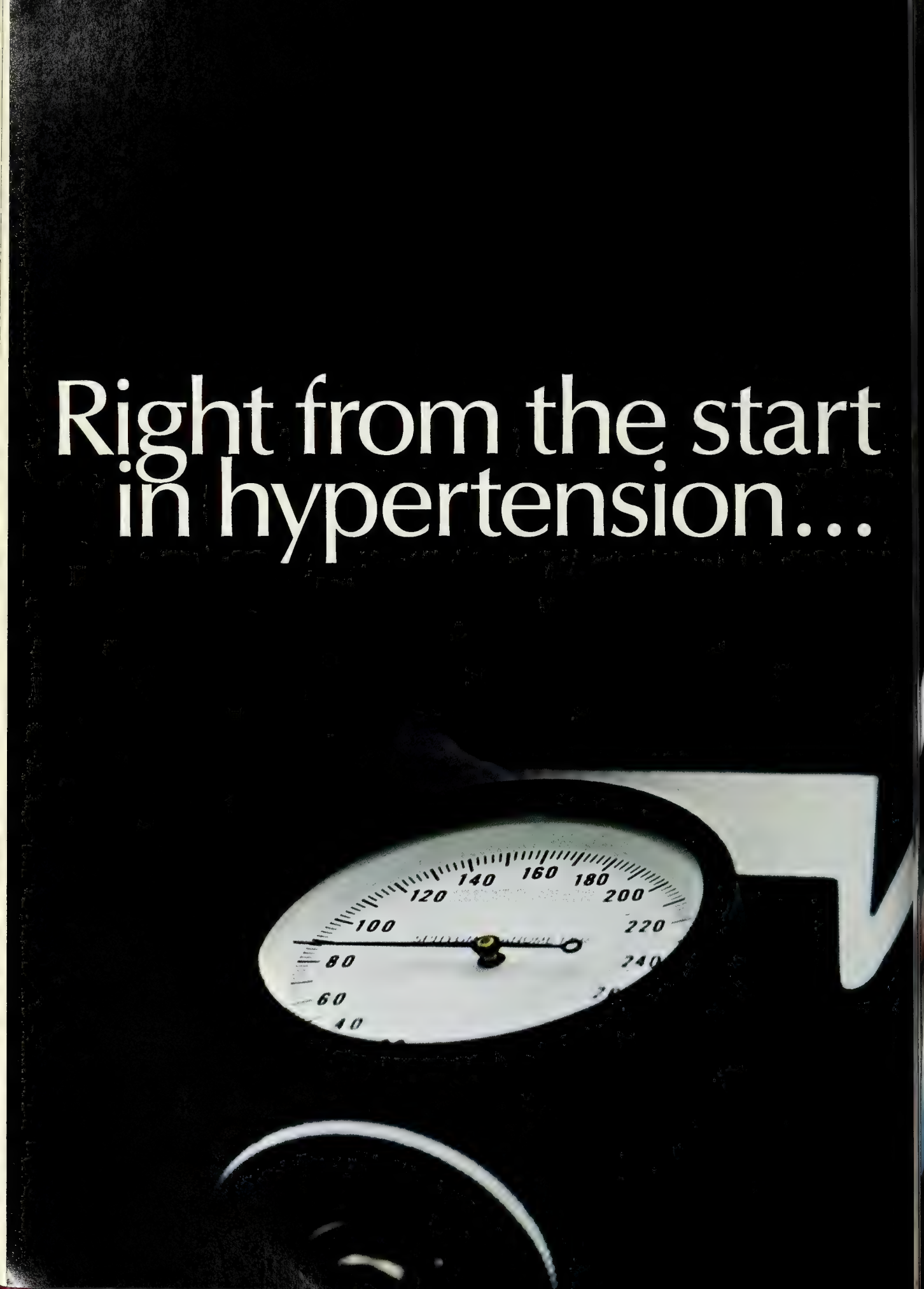
In this annual reference issue you will find a listing of your colleagues who serve as society officers, trustees, delegates, and members of councils and committees. Please use this issue as a reference throughout the year to contact these individuals with your suggestions and ideas. Even more important, use it to suggest places where you might volunteer your own time and expertise.

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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS. Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimum migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximum dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

REFERENCES

1. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768. **2.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299.

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ALZHEIMER'S DEMENTIA

Cure of the disease is still out of reach. In as devastating a condition as this, even the most modest relief of symptoms—or for that matter keeping them from getting worse or merely slowing their intensification—is a great contribution to patient and family.

HYDERGINE® LC (ergoloid mesylates) is indicated for patients over age sixty who manifest signs and symptoms of idiopathic mental decline. It appears that individuals who respond to HYDERGINE LC therapy are those who would be considered to suffer from some ill-defined process related to aging or to suffer from some underlying condition such as Alzheimer's dementia.

Before prescribing HYDERGINE therapy, the possibility that the patient's signs and symptoms arise from a potentially reversible and treatable condition should be excluded. In addition, because the presenting clinical picture may evolve to suggest an alternative treatment, the decision to use HYDERGINE therapy should be continually reviewed.

HYDERGINE® LC
(ergoloid mesylates)
liquid capsules, 1 mg

THE ONLY PRODUCT INDICATED FOR ALZHEIMER'S DEMENTIA.

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HYD-1085-13

For Brief Summary, please see following page.

HYDERGINE® LC
(ergoloid mesylates) liquid capsules 1 mg

Indications: Symptomatic relief of signs and symptoms of idiopathic decline in mental capacity (i.e., cognitive and interpersonal skills, mood, self-care, apparent motivation) in patients over sixty. It appears that individuals who respond to HYDERGINE therapy are those who would be considered clinically to suffer from some ill-defined process related to aging or to have some underlying dementing condition, such as primary progressive dementia, Alzheimer's dementia, senile onset, or multi-infarct dementia. Before prescribing HYDERGINE® (ergoloid mesylates), the physician should exclude the possibility that signs and symptoms arise from a potentially reversible and treatable condition, particularly delirium and dementiform illness secondary to systemic disease, primary neurological disease, or primary disturbance of mood. Not indicated for acute or chronic psychosis regardless of etiology (see **Contraindications**).

Use of HYDERGINE therapy should be continually reviewed, since presenting clinical picture may evolve to allow specific diagnosis and specific alternative treatment, and to determine whether any initial benefit persists. Modest but statistically significant changes observed at the end of twelve weeks of therapy include: mental alertness, confusion, recent memory, orientation, emotional lability, self-care, depression, anxiety/fears, cooperation, sociability, appetite, dizziness, fatigue, bothersome(ness), and overall impression of clinical status.

Contraindications: Hypersensitivity to the drug; psychosis, acute or chronic, regardless of etiology.

Precautions: *Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing HYDERGINE (ergoloid mesylates) preparations.*

Adverse Reactions: Serious side effects have not been found. Some transient nausea and gastric disturbances have been reported, and sublingual irritation with the sublingual tablets.

Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3-4 weeks.

How Supplied: HYDERGINE LC (liquid capsules); 1 mg, oblong, off-white, branded "HYDERGINE LC 1 mg" on one side, "S" other side. Packages of 100 and 500. (Encapsulated by R. P. Scherer, N.A., Clearwater, Florida 33518).

HYDERGINE (ergoloid mesylates) tablets (for oral use); 1 mg, round, white, embossed "HYDERGINE 1" on one side, "S" other side. Packages of 100 and 500.

Each liquid capsule or tablet contains ergoloid mesylates USP as follows: dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

Also available: HYDERGINE sublingual tablets; 1 mg, oval, white, embossed "HYDERGINE" on one side, "78-77" other side. Packages of 100 and 1000. 0.5 mg, round, white, embossed "HYDERGINE 0.5" on one side, "S" other side. Packages of 100 and 1000.

HYDERGINE liquid; 1 mg/ml. Bottles of 100 mg with an accompanying dropper graduated to deliver 1 mg. [HYD—ZZ24—6-15-84]

Before prescribing, see package circular for full product information. HYD-1085-13

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Join Your Colleagues in Developing . . .

A Blueprint for Action: ISMS Directions for 1986-87

The Illinois State Medical Society's 1985 All-Member Conference is fast approaching. Headlining this year's agenda are topics such as PPOs, physician contract negotiations, joint ventures, the future of medical malpractice reform, image building for medicine and organizing an effective hospital medical staff. There is still time to register for this important issues forum, slated for November 2-3, 1985, at the Continental Regency Hotel in Peoria, Illinois.

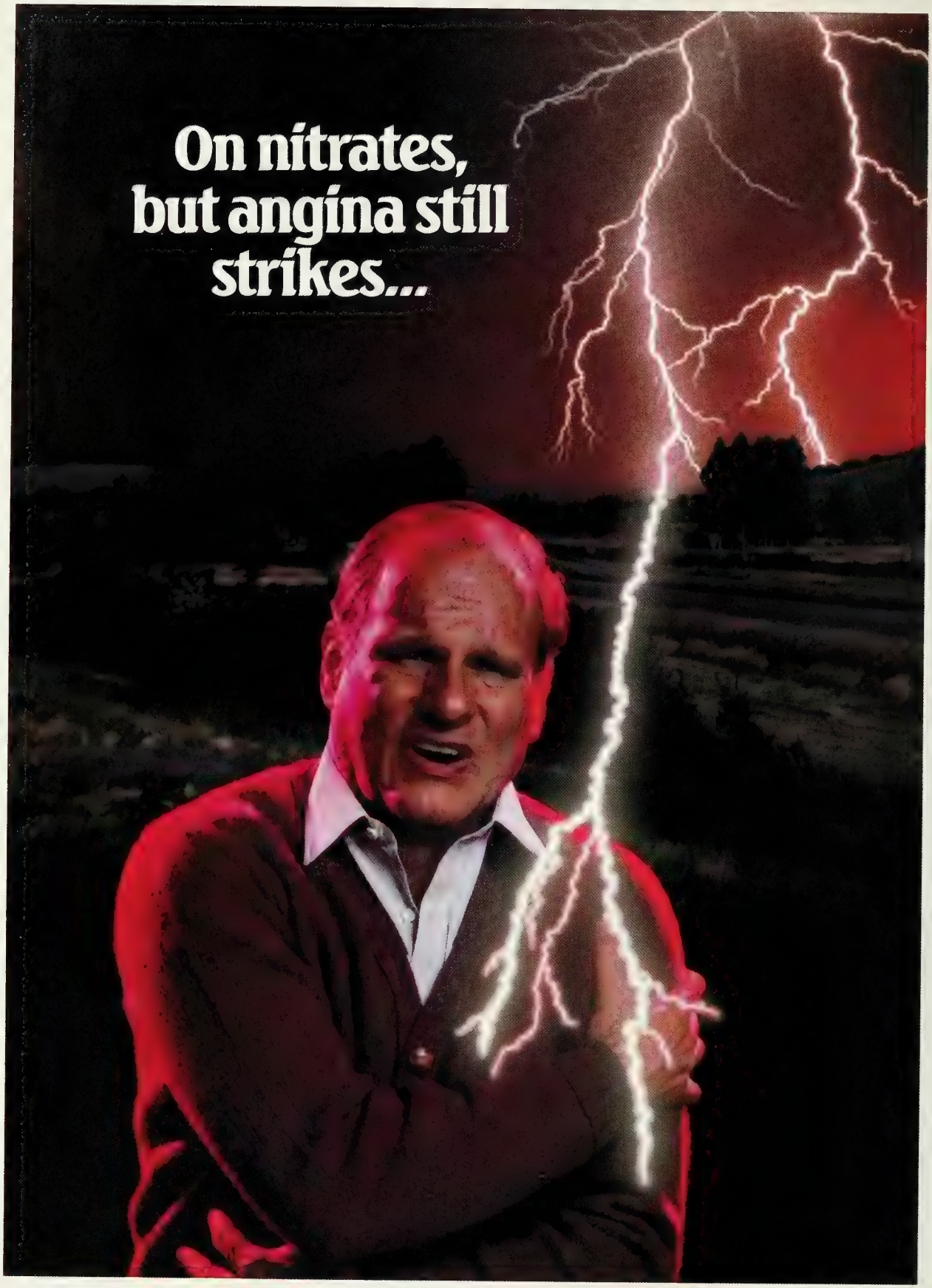
CBS Network News Legal Correspondent Fred Graham will address America's civil justice system, and the need for reform, in a major speech before ISMS conference participants. Graham has monitored the burgeoning movement to rebalance the civil justice system from the journalistic perspective: a movement engendered by both medicine and other professional and business interests.

What does the public think of doctors, and what can improve that image? A full morning session will be devoted to this question, with presentations by expert pollster Robert Teeter of Market Opinion Research and Dr. Barry Kaufman of Chicago's WMAQ Television Health Unit.

The conference will prominently feature new health care finance issues—PPOs, HMOs, IPAs, contract negotiations—facing physicians in these days of cost-cutting. Workshops stressing the practical side of dealing with these and other new health care finance mechanisms will be offered to participants. Expert negotiator J. Paige Clousson will explore ways to sharpen physician negotiating skills and to increase the profession's knowledge of health care finance contracts. He will be joined by other specialists in the field of negotiating for medicine.

This year's conference would not be complete without a discussion of malpractice reform—highlighting both achievements and challenges ahead. In step with physicians' increased legislative and political action on malpractice, the ISMS All-Member Conference will offer a preview of Illinois' 1986 election season, featuring assessments by experts of both political parties.

For further information on this year's ISMS All-Member Conference, see the advertisement on page 287 of this issue. Or call ISMS at (312)782-1654. ◂


On nitrates,
but angina still
strikes...

After a nitrate, add ISOPTIN®
(verapamil HCl/Knoll)

To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

First, Isoptin not only reduces myocardial oxygen demand by reducing peripheral resistance, but also increases coronary perfusion by preventing coronary vasospasm and dilating coronary arteries — both normal and stenotic. These are antianginal actions that no beta blocker can provide.

Second, Isoptin spares patients the beta-blocker side effects that may compromise the quality of life.

With Isoptin, fatigue, bradycardia and mental depression are rare. Unlike beta blockers, Isoptin can safely be given to patients with asthma, COPD, diabetes or peripheral vascular disease. Serious adverse reactions with Isoptin are rare at recommended doses; the single most common side effect is constipation (6.3%).

Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin... for more comprehensive antianginal protection without side effects which may cramp an active life style.



ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN®
(verapamil HCl/Knoll)
80 mg and 120 mg scored, film-coated tablets

Contraindications: Severe left ventricular dysfunction (see *Warnings),* hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.)* Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment; however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings.*) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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OBITUARIES

***Blackburn, William H.,** Aurora, died September 2, 1985 at the age of 67. Dr. Blackburn was a 1941 graduate of the University of Illinois College of Medicine, Chicago.

***Collins, Jerre C., Jr.,** Edwardsville, died July 1, 1985 at the age of 71. Dr. Collins was a 1943 graduate of the University of Illinois College of Medicine, Chicago.

****Delicate, William E.,** Edwardsville, died August 23, 1985 at the age of 81. Dr. Delicate was a 1929 graduate of Jefferson Medical College, Thomas Jefferson University, Philadelphia, Pennsylvania.

****Engbring, Gertrude M.,** Effingham, died August 25, 1985 at the age of 87. Dr. Engbring was a 1928 graduate of the Loyola University Stritch School of Medicine, Maywood.

****Fleming, Arthur W.,** Des Plaines, died September 2, 1985 at the age of 78. Dr. Fleming was a 1935 graduate of Rush Medical College, Chicago.

****Foster, Allan A.,** Peoria, died July 4, 1985 at the age of 101. Dr. Foster was a 1909 graduate of the Chicago College of Medicine and Surgery.

***Janzen, Erwin M.,** Springfield, died August 23, 1985 at the age of 61. Dr. Janzen was a 1948 graduate of the University of Louisville School of Medicine, Louisville, Kentucky.

Kushino, Kenji, Chicago, died August 11, 1985 at the age of 66. Dr. Kushino was a 1950 graduate of the University of Illinois College of Medicine, Chicago.

***Lappe, Robert J.,** Chicago, died August 22, 1985 at the age of 59. Dr. Lappe was a 1957 graduate of the Loyola University Stritch School of Medicine, Maywood.

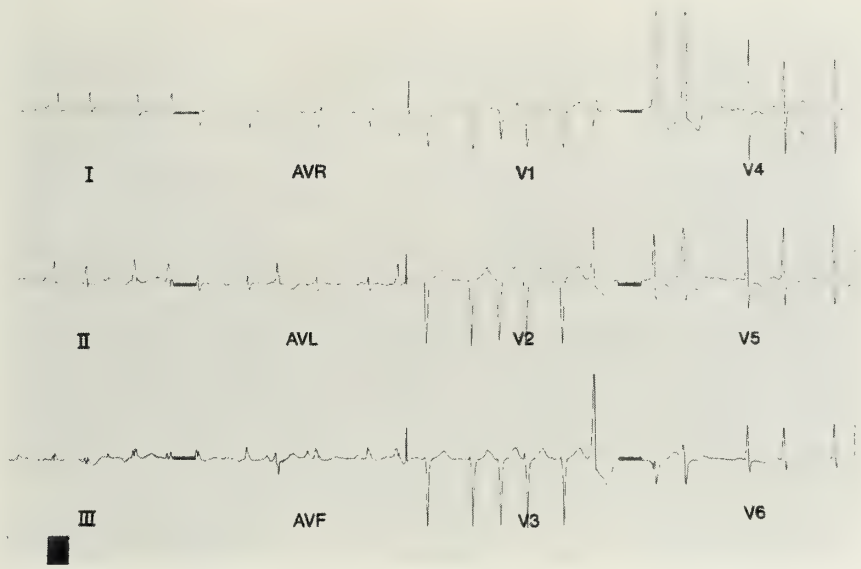
****Miller, C. Phillip, Jr.,** Chicago, died September 4, 1985 at the age of 91. Dr. Miller was a 1919 graduate of Rush Medical College, Chicago.

****Seifert, Martin H.,** Wilmette, died August 20, 1985 at the age of 82. Dr. Seifert was a 1931 graduate of the University of Illinois College of Medicine, Chicago.

**Indicates ISMS member*
***Indicates member of ISMS Fifty Year Club*

EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This is a 73 year-old man who presented to the emergency service with recent onset hemoptysis. The morning of admission, he had coughed up bright red blood ten times, including once in the emergency room. He was known to have dyspnea from chronic obstructive pulmonary disease. He denied any increase in his dyspnea, excess sputum production or pleuritic chest pain. In addition to his long history of chronic obstructive pulmonary disease, he had a history of old myocardial infarction and congestive heart failure. He had a 60 package per year history of cigarette smoking. He admitted to smoking five cigarettes per day now. His physical examination showed a blood pressure of 120/60mmHg, an irregular pulse of 130 to 140 beats per minute, and a respiratory rate of 24 per minute without accessory muscle use. There was no jugular venous distension or lymphadenopathy. Examination of the lungs showed a few bibasilar crepitant rales, diffuse inspiratory and expiratory wheezes, and decreased breath sounds in the bases. The heart rhythm was irregular. There was an active precordium with a left parasternal lift and a grade 3/6 systolic murmur heard best at the left sternal border. Clubbing of fingers and toes with a trace of pedal edema was present. This twelve lead ECG was obtained.

Questions:

1. **The twelve lead ECG shows:**
 A. Atrial fibrillation with a rapid ventricular response.
 B. Junctional tachycardia.
 C. Multifocal atrial tachycardia.
 D. Premature ventricular beats with a couplet.
 E. Old anteroseptal myocardial infarction and nonspecific ST-T wave changes compatible with ischemia.

2. **Appropriate early treatment measures to consider could include:**
 A. Arterial blood gases and a chest x-ray.
 B. Fiberoptic bronchoscopy.
 C. Endotracheal intubation with the respirator.
 D. Digoxin or verapamil.
 E. Antibiotics.

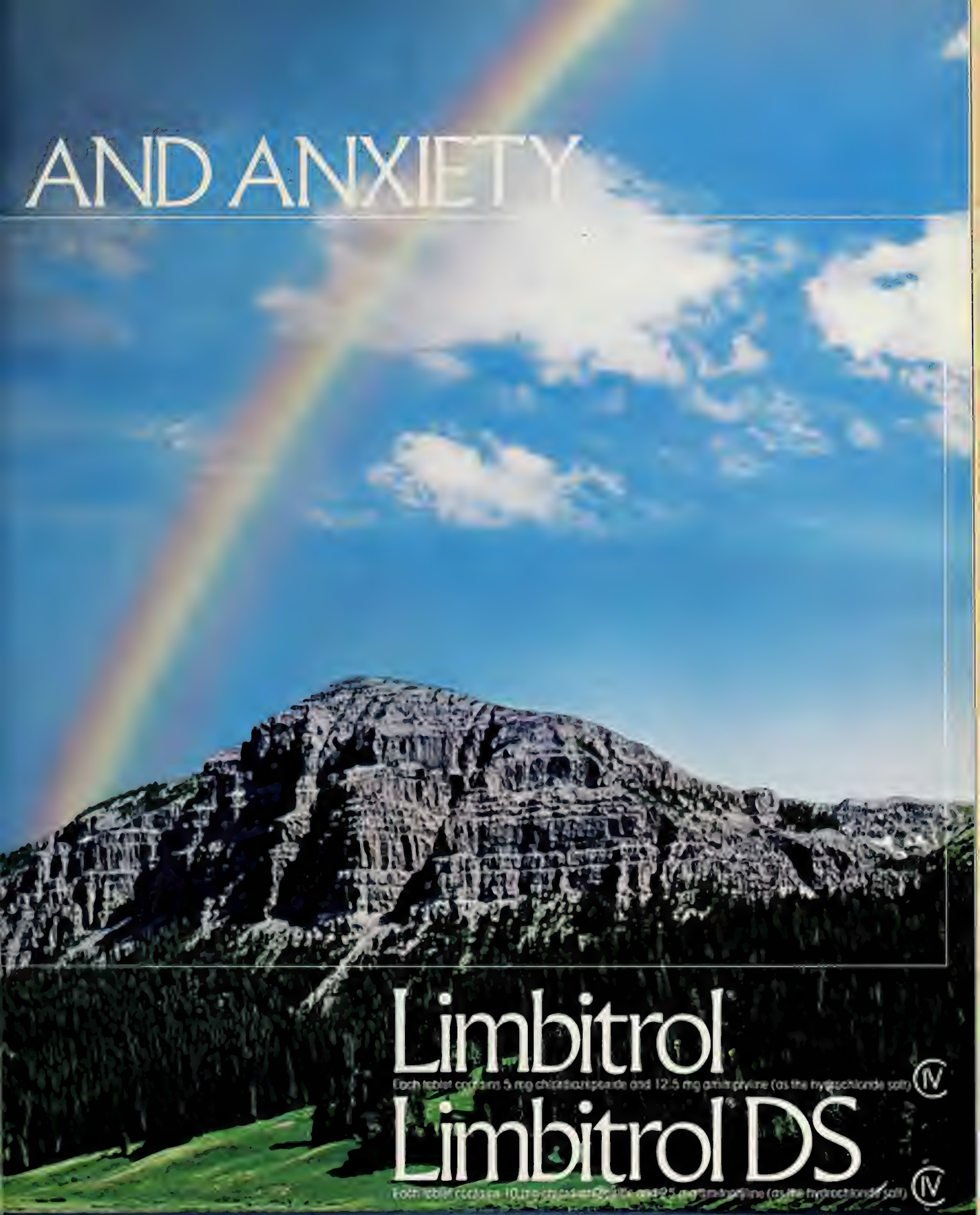
(Continued on page 290)

in moderate depression and anxiety

CLEARING: BOTH DEPRESSION...



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Easier to remember... easier to prescribe

Please see summary of product information on following page.

Limbitrol® Ⓥ **Tranquilizer–Antidepressant**
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).
***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide)
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated, sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice; alopecia, parotid swelling
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.
Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: *Double strength (DS) Tablets*, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets*, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt). Available in bottles of 100 and 500; Tel-E-Dose® packages of 100, Prescription Paks of 50

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Filing Procedure For Crossover Claims Clarified

Some physicians are beginning to experience MMIS claim rejection when submitting "crossover" claims to IDPA. Crossover claims are considered to be MMIS claims for Medicaid recipients who are also eligible for Medicare benefits. Medicaid is always the payor of last resort. Therefore, when submitting crossover claims, physicians should bill the Medicare Part B program prior to forwarding these claims to IDPA.

Physicians billing crossover claims must identify IDPA as the secondary payor in 'box 9' on the HCFA 1500 claim form. Additionally, the recipient I.D. number must be included in the appropriate field, and the physician *must* accept assignment by completing box 26. Physicians who still utilize the SSA 1490 for Medicare/Medicaid crossover claims must include this information in the appropriate fields on that claim form.

Physicians should first determine Medicare eligibility before submitting Medicare/Medicaid crossover claims. Do not bill IDPA until you have received a copy of the explanation of medical benefits (EOMB). If a patient is not eligible for Medicare Part B benefits, the explanation of medical benefits or notification indicating beneficiary ineligibility should be appended to the claim form and forwarded to IDPA. Once a physician verifies that a patient is ineligible for Medicare Part B benefits, all subsequent claims for services rendered to that patient may be submitted directly to the Department of Public Aid.

Once ineligibility has been established, additional evidence of ineligibility is not required. Physicians who have questions or require further clarification of IDPA policies/procedures may contact the ISMS Division of Health Care Finance at (312) 782-1654. Cook County physicians may contact the Chicago Medical Society for assistance at (312) 670-2550. ◀

Angina comes in many forms...

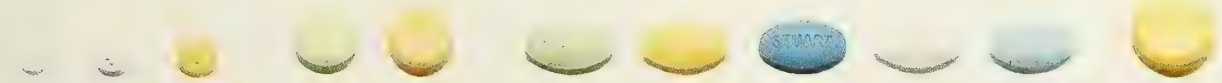


So does

SORBITRATE®

(ISOSORBIDE DINITRATE)

Unsurpassed flexibility in nitrate therapy.



2.5 mg 5 mg 10 mg
Sublingual Tablets

5 mg 10 mg
Chewable Tablets

5 mg 10 mg 20 mg 30 mg 40 mg
Oral "Swallow" Tablets

40 mg
Sustained Action "Swallow" Tablets

See following page for brief summary of prescribing information.

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SORBITRATE®
(ISOSORBIDE DINITRATE)

Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks. Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis.

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites. Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established. If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension.

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE. The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy.

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary.

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur. Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory. The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined. However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals. On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months.

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers. In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal. The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly.

Information for Patients: Headache may occur during initial therapy with SORBITRATE. Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use.

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates.

Isosorbide dinitrate acts directly on vascular smooth muscle; therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug. A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet.

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose. There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman.

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established.

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related. In clinical trials at various doses, the following have been observed.

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent. Cutaneous vasodilation with flushing may occur. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur. Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg; for oral (swallowed) tablets, 5 to 20 mg; and for controlled-release forms, 40 mg.

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose. In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure.

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours. Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported.

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended. The extent to which development of tolerance should modify the dosage program has not been defined. *The oral controlled-release forms of isosorbide dinitrate should not be chewed.*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg); Chewable Tablets (5, 10 mg); Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg)

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Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal.* The *Journal,* however, will secure author permission before authorizing a reprint.

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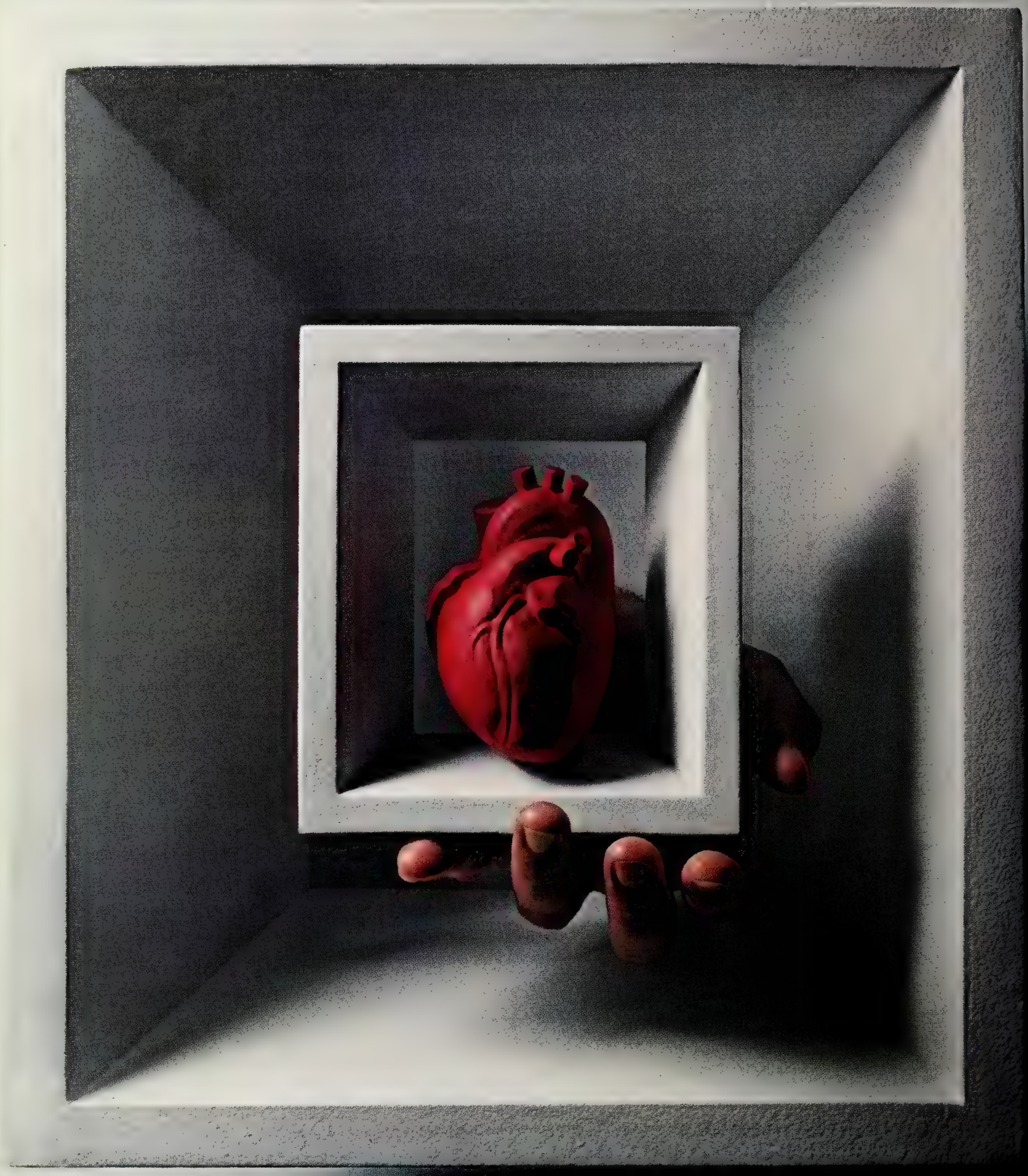
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IMJ

Illinois Medical Journal
Illinois State Medical Society

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ISMS Organization

History of Founding and Expansion

Twenty-nine physicians met in Springfield June 4, 1850, to organize on a permanent basis the Illinois State Medical Society, which had been started informally 10 years earlier. The founders were concerned with the solution of ethical, scientific, legislative and economic problems. The first Constitution and Bylaws and the first Code of Medical Ethics were adopted, the first legislative committee was appointed, and a resolution outlining the beginnings of interprofessional relations was approved.

The Legislative Committee was instructed to "memorialize the legislature at its next session, praying the enactment of a statute providing for the registration of Births, Deaths and Marriages." The resolution ruled that "members of the Society will discourage the sale of patent or secret nostrums on the part of Druggists and Apothecaries throughout the State, and will patronize insofar as practicable, only those who abstain from the sale of such patent or secret nostrums."

The first full time secretary of the Society was Dr. Harold M. Camp who served for over 35 years until his death in 1959. The first executive administrator, Robert L. Richards, was employed at the time the office was moved to Chicago in 1960 and served until February, 1966. After an interim service by Dr. George F. Lull, Mr. Roger N. White was selected to fill the post in May, 1968. He was succeeded by the present executive administrator, Mr. Alexander R. Lerner, in May, 1981. Another milestone was reached in October, 1984, when the headquarters offices relocated to Twenty North Michigan Avenue, Chicago 60602.

The Society published the early transactions in book form, presenting not only the minutes of the House of Delegates, but also all scientific papers given at each annual convention. In 1899 a new era of communications began, for at that time, the *Illinois Medical Journal* was established and became the first "official organ of the Society."

Dr. G. N. Kreider was its first editor and served until 1913, followed by Dr. Clyde D. Pence with Dr. Henry G. Olds as the first managing editor. Dr. Charles G. Whalen became editor in 1919 and he and Dr. Olds served until they died in 1940. Dr. Camp followed Dr. Whalen, and Dr. Theodore R. VanDellen was the editor for 18 years ending 1977. Subsequently, an Editorial Board was established under chairmanship of Dr. J. William Roddick, Jr., to review and determine clinical content for the *IMJ*. The Editorial Board reports to the ISMS Publications Committee.

Dr. Whalen spearheaded many important activities in medicine, and has been called "the outstanding champion of the medical profession in its economic contacts." He has been credited as one of the first medical editors to blast "the socialization of medicine in this country." In 1922, he wrote extensively on state medicine, workmen's compensation, compulsory health insurance, free hospitalization and federal aid.

The first Fifty Year Club in the United States was announced by the *Illinois Medical Journal* in 1938.

The fourth largest medical society in the country has developed from these embryonic beginnings. This edition of the *Illinois Medical Journal* offers you an opportunity to contrast the extensive services available to the membership today with those offered in the past.

ISMS Code of Ethics

WHEREAS, The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient; and

WHEREAS, As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals and to self; therefore be it

RESOLVED, That the following Code of Ethics be adopted by the Illinois State Medical Society not as laws, but standards of conduct which define the essentials of honorable behavior for the physician:

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or those who engage in fraud or deception.
3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.
4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences, within the constraints of the law.
5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical service.
7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Adopted by the Illinois State Medical Society
House of Delegates
November, 1981

Illinois State Medical Society Constitution and Bylaws

Adopted, 1903
As Amended, 1985

Constitution

Article I. Name

The name and title of this organization shall be the Illinois State Medical Society.

Article II. Purposes of the Society

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

Article III. Component Societies

Component societies shall consist of those county medical societies which hold charters from this Society.

Article IV. Composition of the Society

The Society shall consist of active members and such other members as the Bylaws may provide.

Article V. House of Delegates

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society.

Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws.

Section 3. The House of Delegates shall elect members to serve on the Judicial Panel. The Judicial Panel shall perform all judicial functions on behalf of the Illinois State Medical Society, shall review all questions of ethics and shall interpret all rules and regulations of the Society. Further, it shall conduct all hearings on appeals taken from decisions of component medical societies, arising out of disciplinary actions against physicians.

Article VI. Officers

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, and such trustees and other officers as the Bylaws may provide.

Article VII. Board of Trustees

The Board of Trustees, whose duties are executive, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

Article VIII. Conventions and Meetings

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates which shall be open to all registered members.

Article IX. The Seal

This Society shall have a common seal with power to break, change or renew the same when necessary.

Article X. Amendments

The House of Delegates may amend this Constitution at any annual or interim business meeting of the House of Delegates provided that the amendment shall have been proposed at a preceding annual or interim business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.

BYLAWS

CHAPTER I. MEMBERSHIP

Section 1. Members. Members shall consist of Regular members, Emeritus members, Retired members, Service members, Distinguished members, In-training members and Student members. Members enjoy full rights and privileges, including the right to vote and hold office and are counted in determining the strength of the Society's Delegation to the American Medical Association.

A. Regular Members. Regular members shall be those physicians licensed to practice medicine in all its branches in the State of Illinois, who are either residents of the State of Illinois or who practice principally in Illinois, are persons of good moral character and professional standing and members of their ISMS component society.

Members in good standing moving out of Illinois may retain membership (not to exceed one year) in the Illinois State Medical Society until they are accepted into membership in the medical society of the state to which they have moved.

Physicians serving as full-time employees of the American Medical Association and other physicians licensed in one of the states or territories of the United States but not licensed in Illinois may become regular members although they are not actively engaged in the practice of medicine.

B. Emeritus Members. Emeritus members are those who have been regular members in good standing for thirty-five years and have reached or will have reached the age of seventy before the next fiscal year of the Society, have made written application which is received by their component society prior to December 31 and have been recommended by their component society for emeritus status. Such membership shall be effective January first of the year following election. Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of the Society for at least five years.

C. Retired Members. Retired members shall consist of those who have been regular members and who by reason of age or incapacity have retired from active practice and who upon application and recommendation from their component society have been made retired members. Retired status is not available to physicians who assume compensated positions in the health care field after retiring from medical practice.

D. Service Members. Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively fulltime in their respective service, and thereafter if they have been retired on account of age or physical disability, shall be elected to service membership.

E. Distinguished Members. Physicians of Illinois or other states or foreign countries who have risen to prominence in the profession, teachers of medicine or of the sciences allied to medicine, not eligible for regular membership, or members of associated arts and sciences, who have made significant contributions to medicine may be nominated by any member of the House of Delegates and may be elected by the House at any annual convention by a two-thirds affirmative vote of those present and voting. They shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other society activities.

F. In-Training Members. In-training members are persons who are medical school graduates, of good moral character and professional standing and serving an internship or residency approved by the American Medical Association in the State of Illinois and are members of a component medical society. Membership shall end at the end of the year in which training is terminated. Following this, in-training members may apply for regular membership through their component society.

G. Student Members. Student members are those who are currently enrolled in an Illinois medical school or are Illinois residents enrolled in an approved medical school within the boundaries of the United States, are of good moral character, professional and academic standing and student members of a component society.

Section 2. Discrimination of Membership. Membership in the Illinois State Medical Society shall not be denied or abridged because of color, creed, race, religion, sex or ethnic origin.

Section 3. Tenure and Termination.

A. Tenure of Membership. The name of a physician on a properly certified roster of members of a component society which has paid its annual assessments, shall be prima facie evidence of membership so long as he complies with the provisions of this Constitution and Bylaws. A member shall hold only one type of membership at any one time.

B. Termination of Membership. Any person who is under sentence of suspension or expulsion from a component society shall not be entitled to any of the rights or benefits of the society nor shall he be permitted to take part in any of the proceedings until he has been reinstated. Suspension will in no way affect insurance benefits.

A member whose dues are unpaid by March 31 of the current year ceases to be in good standing and shall be notified of his delinquency by the secretary. A member whose dues or assessments remain unpaid on April 30 of the current year shall automatically be dropped from membership. An individual who has forfeited membership for non-payment of dues or assessments may be reinstated as a member before two years have elapsed, providing, in the interim, he has not been guilty of conduct prejudicial to membership, by the full payment of all dues or assessments in arrears from the date that he was last in good standing. If two or more years have elapsed since he was a member in good standing, he will be required to make application as a new member.

Any member in good standing who resigns voluntarily by December 31 of any year may be reinstated within one year of his resignation by paying all dues and assessments that fell due during the period that his membership lapsed. If more than one year has elapsed since his resignation, he must apply as a new member. Any past member who regains membership by payment of all dues and assessments in arrears shall be eligible for membership benefits only to the extent and in the same manner as a new member initially joining the society.

CHAPTER II. DUES AND ASSESSMENTS

Section 1. Dues. Annual dues may be levied by the House of Delegates on each class of membership. The amount of dues shall be recommended by the Board of Trustees and shall be fixed by the House of Delegates at the Annual Meeting and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association. These shall include the annual subscription to the *Illinois Medical Journal* which shall be at least fifty percent of the regular subscription price of the *Journal.*

Only Regular, In-training and Student members shall be assessed annual dues. Dues for its members shall be forwarded by the component society prior to March 31 of each year.

Section 2. Reduction and Remission of Dues. Regular members may be given a fifty percent reduction in dues during the first year of practice, upon recommendation of their component society. Physicians approved for membership after June 30 shall pay one-half the annual dues for that year. The Board of Trustees may authorize remission of dues of any member based upon annual review and recommendation of the component society, for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association. Emeritus members, Retired members, Service members and Distinguished members are not required to pay dues.

Section 3. Assessments. In addition to dues, assessments may be made on dues-paying members as may be recommended by the Board of Trustees and approved by the House of Delegates. Unless specifically indicated as voluntary, any assessment passed by the ISMS House of Delegates shall be considered a part of a member's dues for the purposes of membership in this organization.

CHAPTER III.
EDUCATIONAL AND SCIENTIFIC PROGRAMS

Educational and scientific programs shall be provided by the Society at such times and places as recommended by the Board of Trustees and approved by the House of Delegates.

CHAPTER IV. HOUSE OF DELEGATES

Section 1. Composition. The voting membership of the House of Delegates shall consist of 1) delegates elected by component societies, 2) the President, 3) the President-elect, 4) the Vice Presidents, 5) the Secretary-Treasurer, 6) the Speaker and Vice Speaker, 7) Trustees, 8) one delegate elected by the Resident Physicians Section, 9) one delegate elected by the Medical Student Section and 10) one delegate elected by the Hospital Medical Staff Section.

Those having the privilege of the floor without vote are past trustees, past presidents, past speakers, general officers of the American Medical Association, members of the Illinois delegation to the AMA who are not otherwise voting members of the ISMS House of Delegates, and one representative from each member organization of the Council on Affiliate Societies.

Section 2. Delegates. Each component society shall be entitled to send one of its members to the House of Delegates each year for each seventy-five members, not to include student members, and one for a major fraction thereof, but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws shall be entitled to one delegate. The number of delegates to which any component society is entitled shall be determined by the number of members of the component society on membership rolls of the Illinois State Medical Society as of December 31 of the preceding year. The term of office of a delegate shall begin January first following his election and shall be for two years, or until his successor has been elected. Component societies with only one delegate may elect for one year.

Section 3. Affiliate Group Delegates. There shall be a Resident Physicians Section and a Medical Student Section, which shall be open, respectively, to all in-training and medical student members of ISMS. There shall also be a Hospital Medical Staff Section, which shall be comprised of ISMS members elected to represent individual hospital medical staffs. The business of each organization shall be conducted by a governing council in accordance with bylaws approved by the ISMS House of Delegates. The governing council of each organization shall include one delegate with vote in the ISMS House of Delegates and one alternate delegate.

Section 4. Time and Place of Meetings.

A. Annual Meeting. The House of Delegates shall meet in an annual session and may meet in an interim session upon call of the Board of Trustees. The time and place of the annual meeting shall be as the House determines.

B. Interim Meeting. The Board of Trustees may schedule an interim session of the House of Delegates between annual meetings of the House if it determines that there is sufficient, relevant business. An interim meeting of the House should not exceed three days and its business shall be restricted in accordance with the provisions of Section 11 of this chapter. An interim meeting should be held in a district other than that of the preceding annual meeting.

Section 5. Quorum. Fifty delegates representing no less than twenty component societies shall constitute a quorum for the transaction of business.

Section 6. Special Meetings. Special meetings of the House of Delegates may be called by a majority of the Board of Trustees or upon petition of twenty component societies. When a special meeting is called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called.

Section 7. Registration. Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the President/or the Secretary of his component society stating that the delegate or alternate has been regularly elected to the House of Delegates. A delegate or his alternate may be seated without credentials, provided he is properly identified and is certified to the secretary of the Illinois State Medical Society. Whenever a delegate or his alternate are unable to attend a particular meeting, the component society may select and certify a substitute delegate who shall have the same powers and duties as did the delegate. A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until the final adjournment of that session. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by the committee. After the alternate has been seated, he cannot be replaced for that session.

Section 8. District Division. The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

Section 9. Order of Procedure. The order of business of the House of Delegates shall be determined by the Speaker, subject to approval by the Reference Committee on Rules and Order of Business. Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

Section 10. Privilege of the Floor. The House of Delegates by two-thirds vote of those present and voting, may extend an invitation to address the House to any person who in its judgment might assist in its deliberations.

Section 11. Introduction of Resolutions and Other Business. All resolutions must be introduced by a voting member of the House. Resolutions submitted nine weeks prior to the annual or interim meeting of the House will be listed in the delegates handbook citing author and subject only; a full copy of all resolutions will be mailed to the delegates. Resolutions to be mailed to the delegates prior to the annual or interim meeting must be received at ISMS headquarters 30 days prior to the annual or interim meeting. Resolutions received after the above date must be approved by the Committee on Rules and Order of Business or by a two-thirds vote of the House of Delegates before they will be considered as business of the House. The only business to be considered by the House of Delegates during an interim meeting will be:

1. Resolutions and information reports introduced by the Board of Trustees as urgent business.
2. Resolutions on matters of national importance and considered urgent introduced by a voting member of the House of Delegates on behalf of the AMA delegation under the same conditions as below.
3. Resolutions introduced by individual delegates, by the Resident Physicians Section, or by the Medical Student Section which are considered urgent and accepted by the Committee on Rules and Order of Business.
4. Decisions of the Committee on Rules and Order of Business regarding the introduction of resolutions at the Interim Meeting may be overruled by a majority of the House of Delegates. Resolutions

which are not considered urgent will be carried over to the next annual meeting.

Reports of committees, councils and officers should be informational and should not contain requests for House action. Recommendations of committees, councils and officers should be submitted to the House in resolution form. Reports, resolutions and requests for action after the opening of the first session of the House of Delegates shall require for consideration a two-thirds affirmative vote.

Section 12. Judicial Panel. The House of Delegates shall create a Judicial Panel and shall elect five (5) of its active members to serve on the Panel, in a manner set forth in Chapter XI of these Bylaws. The Judicial Panel shall review all questions of ethics and shall interpret the laws and rules of the Society. It shall consider all questions of an ethical nature and it shall conduct hearings on appeals taken from decisions of component societies on ethical relations matters and other disputes involving the rights and privileges of physicians.

CHAPTER V. ELECTION OF OFFICERS

Section 1. Officers. The officers of this Society shall consist of the president, president-elect, first and second vice presidents, secretary-treasurer, speaker and vice speaker, twenty-one trustees and one trustee-at-large, and delegates and alternate delegates to the American Medical Association.

Section 2. Elections. All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote.

The majority of votes cast shall be necessary to elect.

The election of officers, delegates and alternate delegates to the AMA, shall follow the completion of action on current and old business at the final session of the House of Delegates.

Section 3. Terms of Office. The president-elect, vice-presidents, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years. The number of consecutive terms that may be served by a trustee is limited to three. This shall become effective July 1, 1975, and shall not have retroactive application.

The speaker and vice speaker shall not be elected for more than two consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

Delegates and alternate delegates to the AMA shall be elected by the House of Delegates for two-year terms, except in the event of their election to fill a portion of another's unexpired term.

The president-elect shall be inducted into the office of president by the retiring president during the final session of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elected and installed. Following his retirement as president, he shall automatically become trustee-at-large for a term of one year.

CHAPTER VI. DUTIES OF OFFICERS

Section 1. The President. The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform other duties as custom and parliamentary usage may require. He shall also appoint such task forces as may be needed by the Society.

Section 2. The President-Elect. The President-Elect shall attend all meetings of the Board of Trustees and the Executive Committee, shall study the relationship between the Chairman of the Board and the President and shall study the responsibilities and duties of the Executive Administrator, Chairman of the Board and President so that when his term as President commences, he will have an understanding of his duties and responsibilities. He shall also serve as chairman of the Committee on Planning and Priorities.

Section 3. The Vice Presidents. The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the president's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice presidency, the second vice president will become first vice president.

Section 4. Successor to President-Elect. In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual convention by election at a time recommended by the Reference Committee on Rules and Order of Business.

Section 5. The Speaker. The Speaker, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint all committees of the House of Delegates.

He shall seek the advice of officers and trustees.

He shall be a member of the Committee on Constitution and Bylaws.

Section 6. The Vice Speaker. The vice speaker shall preside for the speaker in the latter's absence at his request. In case of death, or resignation of the speaker, the vice-speaker shall serve during the unexpired term.

Section 7. The Secretary-Treasurer. In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom, or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.

The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

Section 8. Delegates and Alternate Delegates to the American Medical Association. Members of the Illinois State Medical Society's delegation to the American Medical Association are officers of this society and, as such, share jointly with the Board of Trustees the responsibility for carrying out policies established by the ISMS House of Delegates as they pertain to the AMA activities.

They shall have the privilege of the floor in the ISMS House of Delegates.

Members of the delegation are responsible for participating actively in the House of Delegates of ISMS and the AMA to the extent allowed under the bylaws of each organization. They are responsible for submitting to the AMA appropriate resolutions and they are obliged to seek passage of these resolutions in the AMA House of Delegates until such time as circumstances and/or additional facts make continued effort impractical or impossible.

CHAPTER VII. THE BOARD OF TRUSTEES

Section 1. Composition. The Board of Trustees shall consist of twenty-one trustees elected by the House of Delegates, one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and vice speaker of the House of Delegates, the first vice president and second vice president, and the secretary-treasurer. The Chairman of the Board of Governors of the Illinois State Medical Inter-Insurance Exchange shall sit as an ex-officio member having all privileges except the right to vote. Ten trustees shall be chosen from District 3 and one from each of the other eleven districts.

The trustee districts of the Illinois State Medical Society shall be:

First District—Counties of Kane, Lake, McHenry.

Second District—Counties of Bureau, Ford, Grundy, Iroquois, Kankakee, Kendall, LaSalle, Livingston, Marshall, Putnam, Will, Woodford.

Third District—Cook County.

Fourth District—Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Tazewell, Warren.

Fifth District—Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon.

Sixth District—Counties of Adams, Brown, Calhoun, Cass, Greene, Jersey, Macoupin, Madison, Morgan, Pike, Scott.

Seventh District—Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby.

Eighth District—Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion.

Ninth District—Counties of Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson.

Tenth District—Counties of Monroe, Perry, Randolph, St. Clair, Washington.

Eleventh District—DuPage County.

Twelfth District—Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago.

Section 2. Duties. The duties of the Board of Trustees are executive and custodial.

A. Executive Duties. The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority. The Board of Trustees may establish a not-for-profit corporation of physicians known as the Illinois Foundation for Medical Care.
The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates.

B. Custodial Duties. The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

All money received by the Board of Trustees and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursement of money shall be approved by the Board. The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Board of Trustees before same shall become effective. Funds may be appropriated to encourage scientific investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

Section 3. Executive Administrator. The Board of Trustees shall employ an executive administrator (who, when he shall be a physician, may be designated as the executive vice president) whose duties shall be determined by the Board. He shall be responsible to the chairman of the Board. The Board shall review at each of its meetings the interim activities of the administrator. The Board also shall employ such other people as are needed for the conduct of the affairs of the Society.

Section 4. Meetings. The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

Section 5. Organization.

A. Chairman. The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year. The immediate past president shall temporarily assume the responsibilities of the Chairman of the Board in the latter's absence.

B. Duties of the Chairman. The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board. He supervises the work of the Executive Administrator, appoints members of councils and committees with approval of the Board, and monitors execution of Board decisions and resolutions. He may delegate any of his duties.

Section 6. Quorum. Eleven members of the Board of Trustees from at least seven districts shall constitute a quorum for the transaction of business.

Section 7. County Societies. The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 8. Publication. The Board of Trustees shall provide and superintend the publication and distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

Section 9. Bonding. The Board of Trustees shall provide at the expense of the Society, adequate bond for those officers and employees of the Society it considers require bonding.

Section 10. Duties of Trustees. Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio member of all district committees. He shall report to the Board of Trustees the actions of the component societies in reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. Vacancies. If during the interval between two annual conventions, sickness, death, or removal from the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12. The Benevolence Fund. Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem appropriate to be held in a fund of a separate incorporated entity known as "The Illinois State Medical Benevolence Fund, Inc." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. Contributions and bequests to the Illinois State Medical Benevolence Fund, Inc., shall be deposited forthwith in said fund.

Section 13. Audit and Financial Statement. The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report also shall specify the character and cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

CHAPTER VIII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Peer Review Committee, and such other committees as required to provide to each component society those services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district; except that district committees may be

assigned to act when the Ethical Relations or Peer Review Committees of the component society fail to act as set forth in Chapters XI and XII of these bylaws.

Complaints initially received by district committees shall be referred immediately to the component society for action.

District committees shall be governed by the procedural rules and regulations governing the counterpart state society committee or by these Bylaws.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Physicians elected to district committees shall serve a three year term of office. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

CHAPTER IX. COMMITTEES

Section 1. Committee Structure. The committee structure of the Illinois State Medical Society shall be as follows:

A. Councils (standing committees)
B. Committees Reporting Directly to the Board of Trustees
C. House of Delegates Committees
D. Board of Trustees Committees

Section 2. Councils.

A. The Medical-Legal Council shall be concerned in the areas of:
 1. Liaison with the Illinois Bar Association
 2. Liaison with courts, particularly where impartial medical testimony is involved
 3. Implementation of the Impartial Medical Testimony Rule
 4. Legal aspects of medical practice other than in the area of mental health
 5. Licensing and standards of practice
 6. Quackery
 7. Anatomical gifts and organ transplants

B. The Council on Governmental Affairs shall be concerned in the areas of:
 1. Federal and state legislation—analysis and communication
 2. Legislative liaison—both state and federal
 3. Political education

C. The Council on Education and Manpower shall be concerned in the areas of:
 1. Liaison with medical schools, curricula, etc.
 2. Health manpower and training
 3. Internships, residencies, etc.
 4. Scientific assembly
 5. Student loans
 6. Continuing medical education

D. The Council on Economics shall be concerned in the areas of:
 1. Ongoing relationships with third parties
 2. Health care cost and utilization

E. The Council on Medical Service shall be concerned with:
 1. The provision of medical care and health services in the public and private sectors
 2. Emergency medical services
 3. Health care of the poor, aged and those in rural areas
 4. Maternal and child health
 5. Nutrition
 6. Workmen's compensation
 7. Environmental and community health
 8. Rehabilitation
 9. Health care facilities and delivery systems

F. The Council on Public Relations and Membership Services shall be concerned in the areas of:
 1. Publicity and promotion
 2. News media relations
 3. Exhibits and public service programming
 4. Religion and medicine
 5. New member orientation and membership benefit explanation

G. The Council on Mental Health and Addiction shall be concerned in the areas of:
 1. Facilities and services
 2. Liaison with Department of Mental Health
 3. Legal aspects of commitment, etc.
 4. Narcotics and dangerous drugs
 5. Alcoholism

H. The Council on Affiliate Societies shall be concerned in the areas of:
 1. Liaison between the affiliate society and ISMS
 2. Scientific resource information and advice to ISMS
 3. Consultation to other councils, *e.g.*, postgraduate education, health care delivery, publicity, legislation
 4. Advances of medical science in special fields
 5. Recommendations to the Board of Trustees on legislative matters affecting any specialty society
 6. Affiliate Societies
 a. *Qualifications.* Affiliate societies shall be those recognized societies of Illinois
 1. as may be approved by the Board of Trustees
 2. which desire representation on the Council on Affiliate Societies
 b. *Representation.* Each affiliate society shall be entitled to one member on the council. This representative shall be a member of ISMS.

Section 3. Organization of Councils.

A. Councils and the chairmen thereof shall be appointed by the Board of Trustees.
B. Each Council shall have authority to request the Board of Trustees to appoint subcommittees under the councils for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of each subcommittee and shall be selected by the Board of Trustees. Each subcommittee shall be used only for the specific purpose or purposes assigned to it and shall terminate as soon as its final report has been made or at the direction of the Board. The chairman of a Council may not serve as chairman of any subcommittee of the Council.
C. Members of the Illinois State Medical Society (who are not members of the Board of Trustees) may be appointed to serve as chairmen or members of any council or committee. Students nominated by the Governing Council of the ISMS Medical Student Section and resident physician members nominated by the Governing Council of the ISMS Resident Physicians Section may be appointed by the Board of Trustees as members of any appropriate council or committee. Such members shall be permitted full privileges of committee membership, including the right to vote. Members of the Board of Trustees may serve as advisory members to any council or committee.

 Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society.

 A state committee which reviews the decisions of a similar committee of a component society may not have as a member one who currently serves on the same committee of a component society or district.
D. Each Council shall submit for adoption a budget for the ensuing year which shall include any subcommittees, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.
E. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members without vote of the various Councils and task forces, and may attend all committee meetings.
F. Terms of office of members of the councils shall be one year, but may be terminated at any time at the discretion of the Board. No member of a council shall serve more than five consecutive one-year terms.
G. Vacancies on any council or subcommittee thereof may be filled or membership therein may be enlarged or decreased by the Board of Trustees. The areas of concern of councils may also be enlarged or decreased by the Board of Trustees.
H. The chairman of a council or subcommittee thereof, when he considers it expedient and with the consent of two-thirds of the members of the council, may conduct business or hold meetings by mail or by conference call, provided all members of the council are given opportunity to participate, that minutes of the transactions are recorded, approved by

members participating, and circulated among all members.

I. Reports of subcommittees shall be made by the chairman to the council under which they are operating.

Reports of council activities shall include recommendations on reports and requests from subcommittees, and shall be made to the Board of Trustees by the chairman of the council.

The chairman of any subcommittee may request the Board of Trustees to allow him, or any member of his subcommittee, to appear before the Board and to be heard.

All councils shall submit to the House of Delegates written reports summarizing all actions. Requests for House action or recommendations affecting medical society policy must be submitted to the House in resolution form.

Section 4. Task Forces. A task force, an ad hoc body to address a specific complex issue and report by a date certain to the Board of Trustees, shall be appointed by the President upon direction of the House of Delegates or request of the Board of Trustees. It shall consist of persons from any two or more of the following categories: council members, committee members, other members of the Society, non-members of the Society. It shall be dismissed upon making its final report.

Section 5. Committees Reporting Directly to the Board of Trustees

A. Planning and Priorities Committee. This committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties, it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President. The President-Elect shall serve as chairman of the committee.

B. Committee on Insurance. This committee will review society-sponsored insurance programs, study these plans, make suggestions for changes, additions and cancellation of policies, and will investigate other insurance programs that may benefit society members.

C. Committee on Health Planning. The committee has responsibility for keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The committee shall maintain liaison with various organizations as determined by the Board of Trustees.

D. Committee on Drugs and Therapeutics. The Committee shall meet periodically to refine the drug list contained in the Drug Manual. It shall work with the Illinois Department of Public Aid in an effort to keep the Drug Manual current and effective. When suggestions and comments from members are submitted to the committee, it shall review them and present them to the Department of Public Aid when necessary. The committee shall also consider other drug matters affecting the policy of the medical society.

E. Health Data Committee. The Committee shall maintain ongoing awareness of (1) systems for the collection and dissemination of health care data, (2) government, 3rd party and other agency requirements for the reporting of health care data and (3) laws and government regulations pertaining to confidentiality. For committee purposes, health care data includes but is not limited to: (1) hospital patient care statistics, (2) long-term care statistics, (3) ambulatory care statistics, (4) institutional financial data, (5) medical manpower, (6) vital statistics, and (7) information obtained from health care surveys.

The committee shall be knowledgeable of the workings of various organizations as determined by the Board of Trustees.

F. Peer Review Appeals Committee. This committee shall serve as an appellate body for state peer review by considering cases appealed from local or district peer review committees. Peer review involves the medical review of cases concerning the utilization and quality of medical services, as well as patient relation issues. The committee will serve as liaison to local peer review committees and monitors activities around the state.

G. Committee on CME Accreditation. It shall be the responsibility of this committee to adopt necessary procedural rules and to prescribe forms to be used in the conduct of CME accreditation. The committee shall review sponsor applications and survey team reports for intrastate CME sponsors, and make decisions on grant of initial accreditation and continuation of accredited status.

Section 6. House of Delegates Committees. House of Delegates Committees of the Illinois State Medical Society shall be as follows:

A. Committee on Credentials shall consider all questions regarding the registration and credentials of the delegates. It shall distribute and receive the attendance slips for each session of the House of Delegates and perform any other duties assigned to it.

B. Committee on Rules and Order of Business shall consist of five members nominated by the Speaker and confirmed by the House immediately prior to the conclusion of business at its annual meeting. The committee will serve until the next annual meeting.

It shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates. It shall also consider late resolutions for introduction at the annual meeting and resolutions introduced by individual delegates at the interim meeting.

C. Committee on Tellers and Sergeants-at-Arms shall:

1. Serve the speaker of the House of Delegates.
2. Distribute, collect and tally votes when a ballot is taken or a numerical tally is required.
3. Certify those in attendance in closed or executive sessions of the House of Delegates.

D. Committee on Constitution and Bylaws shall consider all proposed amendments to the Constitution and Bylaws. The chairman of the Trustees Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the reference committee, to assist in the preparation of the report of the committee to the House of Delegates.

E. Ad hoc committees may be appointed by the speaker of the House of Delegates as the needs arise and any member of the Illinois State Medical Society may serve upon such committee. The number appointed to such committees shall be at the discretion of the speaker and the term of the committee shall be for such duration as is necessary to complete the task assigned but shall not exceed a duration of one year. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees, keeping it informed of all current activities.

F. Such other reference committees as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive administrator, the reports of committees pertaining to administrative activities, economic activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

Section 7. Organization of House of Delegates Committees.

A. Immediately after the organization of the House of Delegates at each meeting, the speaker shall announce the appointment, from among the members of the House, of such committees as may be deemed expedient by the House of Delegates.

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

B. References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.

C. Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

Section 8. Board of Trustees Committees. The Board of Trustees shall form the following committees within itself:

A. The Executive Committee shall consist of the president, president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer, the trustee-at-large, and the immediate past chairman of the Board, provided he is still a trustee. If the immediate past chairman of the Board is no longer a trustee, the chairman of the Policy Committee shall be a member of the Executive Committee. The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, and the speaker of the House of Delegates, or the vice speaker in his absence, shall serve as ex-officio members of the Executive Committee without vote. The chairman of the Board of Governors of the Illinois State Medical Inter-Insurance Exchange shall sit as an ex-officio member of the Executive Committee without vote.

 The Board of Trustees may delegate to the Executive Committee any authority which it possesses and may authorize it to act in any given situation. In all matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Medical Benevolence Committee and Policy Committee and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

B. The Finance and Medical Benevolence Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society. This committee shall also:
 1. Examine applications to the Society for assistance under the Medical Benevolence program to determine eligibility for assistance;
 2. Keep the names of the beneficiaries confidential and known only to the committee;
 3. Recommend the allotment for each recipient; and
 4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

C. The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

D. The Committee on Constitution and Bylaws shall consist of five members—the Speaker of the House and four members appointed by the Chairman of the Board. It shall:
 1. Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws.
 2. Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws.
 3. Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

E. The Committee on Publications shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal.*

 It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal.* It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

 It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

 It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish format, cover, type faces and general layout of the *Journal.*

 It shall review, edit and supervise the publication of other materials as directed by the Board of Trustees.

F. The Advisory Committee to the Auxiliary shall consist of the immediate past president as chairman, the president and the chairman of the Board of Trustees.

 The committee shall provide advice and assistance to the president of the Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

G. CME Accreditation Appeal Panel. The panel will consist of seven trustees. It will function as a hearing committee when a CME sponsor appeals a decision of the CME Accreditation Committee. The hearing shall be conducted in conformance with written procedures adopted by the Board of Trustees.

H. The Building and Capital Equipment Committee shall consist of the Chairman of the Board, the President, the President-Elect, the Secretary-Treasurer, the Chairman of the Finance Committee, and the Immediate Past Chairman of the Board, provided that person is a Trustee.

I. The Board of Trustees may from time to time appoint such ad hoc committees as it may deem necessary but the duration of such committees shall be temporary and they shall function only for the specific purpose assigned and shall be terminated as soon as final reports have been made or at the direction of the Board.

Section 9. Powers of the Board of Trustees. The Board of Trustees shall have power to increase or decrease the number of its committees, to change the area of concern of such committees, to enlarge or decrease membership and to fill vacancies thereon.

Section 10. Term of Membership. The term of the members of the Board of Trustees Committees shall be for a duration of one year and they shall be selected by the Board annually immediately after the election of officers.

CHAPTER X. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws of ISMS and the constituent society.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not had a fair trial, shall have the right of appeal to the Judicial Panel.

Section 6. When a member in good standing in a component society changes his residence to another county in this state, such change of residence shall terminate his membership

in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes and it shall accompany his application for membership. The board of censors of the society receiving his application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

Section 7. A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in which his county is situated.

Section 9. The secretary of each component society shall forward a list of current officers, delegates and alternate delegates to the secretary of this society no later than 90 days prior to the annual meeting.

Section 10. Any component society which fails to transmit the dues collected from its members prior to March 31 shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

Section 11. Members of the Illinois State Medical Society shall be bound by the Constitution and Bylaws of ISMS.

CHAPTER XI. ETHICAL RELATIONS

Part 1. Component Medical Society. Each component society may have, either by appointment or election, an Ethical Relations Committee whose duty it shall be to conduct disciplinary hearings under this chapter. Although the component society may develop its own procedures for conducting such hearings, each society will, to the extent possible, comply with the general guidelines set forth by the Judicial Panel, which panel is created under this chapter; such guidelines referred to as the *Handbook for the Conduct of Disciplinary Proceedings.*

Part 2. District Ethical Relations Committee. The delegates in each Illinois State Medical Society district, except in a single county district, shall establish a District Ethical Relations Committee. The component society may elect to request that the District Ethical Relations Committee serving its area function in its behalf and shall conduct such disciplinary proceedings as are required. In the event that a component society's Ethical Relations Committee does not make a reasonable effort to hold a hearing on a properly filed complaint, within a reasonable time period, either the complaining party or the physician against whom formal written charges have been brought, may petition the Illinois State Medical Society Judicial Panel to request the District Ethical Relation Committee to intervene and take jurisdiction of the matter. In the event of a dispute resulting from such actions, the Judicial Panel shall determine, as provided in Part 7 of this chapter, the appropriate forum for the hearing.

Part 3. Offenses.

A. Disciplinary action may be taken against any member of a component society when:
 1. The physician has been convicted, adjudged or otherwise recorded as guilty by any court of competent jurisdiction of a felony or a crime involving moral turpitude; or
 2. He has been adjudged or otherwise recorded as guilty by his component society of:
 a. acts of serious misconduct as a physician; or
 b. a violation of the Constitution or Bylaws of his component society, or of the code of Medical Ethics promulgated by the Illinois State Medical Society; or
 3. He has been judged guilty of a violation of a law or regulation by an administrative agency of government resulting in the termination of his privileges, license, or other rights held by the physician.

Part 4. Standards and Procedures.

A. The committee, in its deliberations, shall evaluate acts by the standards established in the Constitution and Bylaws of the Illinois State Medical Society and/or the component medical society of which the accused is a member.
B. Disciplinary action may be initiated by the component society or the ISMS upon receipt of formal written charges filed by any person, alleging violations of any of the offenses enumerated in Part 3 of this chapter. The person filing the complaint may submit it to either the county where the accused physician holds membership or the county where the alleged incident occurred.

 Written charges received by the Illinois State Medical Society shall be referred to the secretary of the component society in which the accused physician maintains membership or practices medicine. The component society may then exercise the choice of proceeding through its own Ethical Relations Committee or referring the complaint to the District Ethical Relations Committee. Disciplinary action may also be initiated upon the filing of a complaint of an alleged violation of any of the listed offenses by a component medical society against a physician, such complaint having been filed by the secretary of the component society, on its behalf.

Part 5. Penalties. The component society's or District Ethical Relations Committee shall submit their recommendations for disciplinary action in writing to the component society. The recommendation shall be to: (a) acquit; (b) censure; (c) suspend; or (d) expel from membership.

The recommendation to censure shall mean an entry will be made in the accused physician's membership file to the effect that the physician has been found guilty of the act complained of and that he has been properly advised of the finding. No deprivation of membership privileges will be imposed.

The recommendation to suspend shall mean that for a fixed period of time, to be determined by the component society, the accused physician shall forfeit his rights to vote and otherwise to participate in the affairs of the local, state and national societies. In all other respects, his membership shall remain intact.

The recommendation to expel shall mean that the membership status and privileges and rights attendant thereto of the accused physician shall be terminated for a period of one year. At the conclusion of the twelve (12) months period, the physician may re-apply for membership in the society; however, he shall then have the burden of demonstrating that the conditions and factors which contributed to this expulsion have since been removed and need not be considered in the process of reviewing his application for renewed membership.

Part 6. Decision by Component Medical Society.

A. The recommendations of the Ethical Relations Committee must be presented to the component society for approval, rejection, modification or reconsideration. The complainant and accused shall be given reasonable advance notice of the date set for the meeting when the committee's recommendations will be considered. The complainant and the accused each may submit a written statement of their respective positions to the component society. If either the complainant or the accused feels that errors were made during the proceeding before the Ethical

Relations Committee or that new and additional relevant information has become available since the committee conducted its hearing, said party shall submit a description of these errors or new evidence to the component society prior to the component society's review. At the discretion of the component society, the complainant, the accused, and their legal counsel may appear before the society to testify.

B. If the component society believes that the new evidence not previously disclosed to the committee is relevant and material or that procedural error was committed, that component society may refer the matter back to the Ethical Relations Committee for reconsideration. The notice shall state the reasons for the referral and shall set a time limit within which a subsequent hearing must be conducted and recommendations must be presented to the component society.

Part 7. Judicial Panel. A Judicial Panel shall be created and empowered to conduct all appellate hearings arising out of Chapter XI of these bylaws and such other appellate proceedings as may derive from disputes or grievances among physicians practicing or residing in the State of Illinois. The panel shall render its decisions based on these hearings and related deliberations. The panel may, on request, adjudicate disputes among individual physicians or physician groups, between component medical societies and district Ethical Relations Committees, and between local medical societies and the Illinois State Medical Society when such disputes involve or impact the individual rights of physicians practicing or residing in this state; except that the Judicial Panel shall have the power on its own initiative to intervene when an Ethical Relations Committee of a component medical society fails to act in a timely manner, as provided in Part 2 of this chapter. The component medical societies and District Ethical Relations Committees shall cooperate with the Judicial Panel in the collection of statistical information for the purpose of identifying the manner in which due process of law is guaranteed to physicians accused of violations of provisions of these bylaws.

A notice of appeal shall be filed with the ISMS Judicial Panel by one of the parties within 30 days after receiving notice of a decision from the component society. Within 15 days after the required filing date for appeal, the party requesting the appeal shall file a written statement with the Judicial Panel which shall include a description of the errors believed to have occurred during the prior proceedings or assertions of the substantive grounds for requesting the Appellate Hearing.

A party may be granted an appeal hearing if: 1) There is reason to believe that procedural error(s) occurred which significantly affected the outcome of the case; 2) There is a showing that those who conducted the initial hearing acted with bias; 3) The evidence upon which the decision was based was not sufficient to support the decision; 4) The evidence was not properly received or considered; or 5) In the sole discretion of the Judicial Panel, there were other reasons which adversely governed the proceedings and denied due process rights to the party requesting the appeal.

The decisions of the Judicial Panel shall be final; except that an appeal may be requested by the accused member under the Constitution and Bylaws of the American Medical Association. The Judicial Panel of the Illinois State Medical Society shall confine all decisions to its proper appellate function which is to sustain, remand or overturn a decision rendered or reduce a penalty imposed by a county society or district ethical relations committee.

Members of the Judicial Panel shall be elected by a majority of the members of the House of Delegates, upon nomination by the President of the Illinois State Medical Society. The panel shall consist of five active members of the Illinois State Medical Society, elected for five-year terms on a staggered basis; except, that of the members elected to fill the initial terms on the panel, one shall be elected for an initial one-year term, one shall be elected to an initial two-year term, one shall be elected to an initial three-year term, one shall be elected for an initial four-year term and one shall be elected to an initial five-year term. Those elected to serve as members of the initial panel may be re-elected to a second full five-year term; however, succeeding members of the panel may only serve one five-year term. Those members of the Judicial Panel elected at the interim meeting in November, 1978, would serve until the next appropriate meeting of the House of Delegates.

In the event a vacancy on the Judicial Panel occurs, the President of the Illinois State Medical Society shall nominate a successor who shall serve, if approved by the Board of Trustees, until the next meeting of the House of Delegates. At its meeting following such interim appointment, the House of Delegates shall elect a member of ISMS to fill the unexpired term on the Judicial Panel by the procedure described in these bylaws. In the event members of the Judicial Panel are unable to participate in an Appellate hearing for any reason, resulting in fewer than three members of the Panel ready and able to participate in a given appeal, the President shall recommend to the Executive Committee of the Board of Trustees and that committee shall appoint additional interim members to fill out the five-member Panel. These interim members shall serve only for the purpose of conducting and participating in the pending Appeal and their term as members of the Panel shall begin and end with the conduct of the Hearing assigned to them by the Executive Committee of the Board of Trustees. The members of the panel shall elect from among them a chairman who shall serve until his successor shall be elected by a majority of the members of the panel.

The panel shall meet as often as necessary in order to assure a reasonably prompt disposition of matters properly placed before it and shall convene on the call of the chairman. Three members of the panel shall constitute a quorum for the transaction of its business.

The panel shall adopt such rules as it deems appropriate for the orderly conduct of its duties. A written copy of such rules shall be made available to each component society and to the chairman of the Board of Trustees. The panel shall publish a *Handbook for the Conduct of Disciplinary Proceedings,* to be approved by the House of Delegates and which shall serve as a general guideline to all component medical societies in the conduct of hearings.

The chairman of the panel shall report to the House of Delegates at each of its annual meetings, thereby informing the members of the House of Delegates of the proceedings and deliberations of the panel during the preceding twelve months.

Part 8. Due Process Safeguards. In all proceedings conducted in accordance with the provisions of this chapter, the accused physician's rights to due process of law shall be honored and observed. The *Handbook for the Conduct of Disciplinary Proceedings* will set forth general guidelines for affording such due process protections.

CHAPTER XII PEER REVIEW

Part 1. Definitions. Peer review is the inclusive term for medical review by practicing physicians of the utilization of medical services, quality of care, professional competency and patient relations issues. Medical Society peer review shall be conducted by the county society where the physician holds membership or where the incident which served as the basis for the peer review complaint occurred. Ethical relations issues identified during deliberations of the county peer review committee, or where appropriate, the District Peer Review Committee may be referred to either the county or district ethical relations committee, as deemed appropriate by the county (district) committee.

Should an adverse decision be made against a physician by a county society where the reviewed practitioner does not hold membership, that decision will have the weight and effect of a decision made by his own county society. Peer Review Committees should apply standards developed by appropriate physician organizations; such standards to be tempered by customs and practice followed in the local community in which the evaluation is undertaken. Decisions and recommendations of Peer Review Committees shall be advisory only.

Part 2. Component Society Procedures.

A. *Responsibilities*—Each component Society may have, either by appointment or election, a review committee whose duties it shall be to review all proper complaints and inquiries brought before it by physicians, patients and, at local

option, other parties. In the event a component Society shall choose not to appoint or elect its own review committee, the component Society may, by action of a majority of its members eligible to vote, delegate the peer review functions to an appropriate physician organization competent to perform these functions within the geographic area served by the component Society or to a District Peer Review Committee as provided for hereinafter. The District Peer Review Committee shall function and operate on behalf of any component Society which does not establish such a committee.

B. *Procedures*—The review committee of the component Society shall establish reasonable rules of procedure but shall not be bound by technical rules applied in courts of law or in administrative hearings conducted by governmental agencies. All complaints and inquiries shall be reduced to writing and shall be signed by the individual making the complaint or inquiry. Complaints received by the Illinois State Medical Society shall be referred to the proper component Society or District Committee.

C. *Timely Reviews*—The review committee of the component Society shall consider all complaints and inquiries properly filed with the Society in a timely manner and shall render its advice within a reasonable period of time following the receipt of a properly submitted complaint or inquiry. In the event the component Society shall fail to act in a timely fashion, as required in its rules of procedure, the party submitting the complaint or inquiry may petition the Peer Review Appeals Committee of the Illinois State Medical Society, as provided for hereinafter, to take jurisdiction of the complaint or inquiry.

D. *Appeals*—Such parties to the proceedings as delineated below, conducted by the component society may petition the Peer Review Appeals Committee of the Illinois State Medical Society to review certain local proceedings of the component society or district committee. A petition for an appeal must set forth one of the following grounds as a basis for the appeal:

1. PROCEDURAL ERROR—The peer review proceeding was not conducted in accordance with written rules established by the component society, district committee, or the Illinois State Medical Society.
2. BIAS—The proceeding was conducted in a biased or arbitrary manner.
3. INCOMPLETE INFORMATION—If information not available to the component society or district committee is submitted to the State Peer Review Appeals Committee, the committee will first determine the relevancy of the new information. The case will be referred to the component society or district committee for reconsideration if the information is deemed to be pertinent and significant by the State Committee.

A member of the Illinois State Medical Society, who is a party to a peer review proceeding and who has received a final determination from the component Society, may file an appeal with the State Peer Review Appeals Committee, in accordance with Section D, as stated above, as a matter of right. A patient who brings a complaint shall enjoy the privilege of petitioning the State Committee to review the decision of a component Society and the State Committee shall, in its sole discretion, determine whether or not to accept the case on appeal. No other parties shall enjoy the privilege to appeal a decision of the component Society.

In the event of an appeal to the Illinois State Medical Society, the component Society shall send to the Illinois State Medical Society a copy of the complaint, the exhibits and the findings and recommendations of the component Society or District Committee. The right to appeal to the Illinois State Medical Society Peer Review Appeals Committee shall be limited to 30 days after the decision of the component Society or District Committee, unless the appellant can provide an acceptable reason for additional time.

Part 3. District Committee. The delegates in each Illinois State Medical Society district, except in a single county district, shall establish a District Peer Review Committee to function in those instances when the component Society chooses to delegate to its District Peer Review Committee the responsibility to perform the review functions set forth in this Chapter. Upon completion of hearings of each complaint or inquiry referred to it by the component Society, the District Committee shall render its findings and recommendations to the component Society for affirmation. The District Peer Review Committee shall also consider complaints or inquiries assigned to it by the Illinois State Medical Society Peer Review Appeals Committee in those instances when it is determined by the State Committee that a component Society has failed to act in a timely fashion on a peer review complaint or inquiry submitted to it.

Part 4. Illinois State Medical Society Procedures.

A. There shall be created a Peer Review Appeals Committee, appointed by and reporting directly to the Board of Trustees. The Committee shall consist of seven members who shall serve one-year terms but, in no event, more than five consecutive one-year terms. Vacancies shall be filled by appointment by the Board.

The Peer Review Appeals Committee shall review appeals of decisions of component or district peer review committees in accordance with the provisions of Part 2 (D) of this chapter. The state committee shall determine the validity of the alleged grounds and, if found valid, remand the case to the local or district committee for a rehearing. If the alleged grounds are found invalid, the decision of the district or county committee shall be deemed to be reaffirmed. The decision of the Peer Review Appeals Committee shall be forwarded first to the county or district committee and then to the appellant. The state committee shall have authority to assign cases to district peer review committees in accordance with Part 3 of this chapter. Decisions of the state committee shall be final.

B. The State Peer Review Appeals Committee shall adopt appropriate rules for the conduct of its business and shall act on all appropriately filed appeals in a timely manner. The State Committee shall notify the appropriate component Society of its decision in a given case prior to its notification of the parties to the appeal.

C. If, in the judgment of the State Committee, a matter submitted to it on appeal is deemed to be more appropriately treated as an ethical relations issue, the Committee shall refer that case for disposition to the Judicial Panel, created under Chapter XI of these Bylaws.

CHAPTER XIII. MISCELLANEOUS

The fiscal year of this Society shall be from January 1 to December 31 inclusive.

CHAPTER XIV. AMENDMENTS

The House of Delegates may amend any article of these Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be acted upon before the day following that on which it was introduced.

CHAPTER XV. PARLIAMENTARY PROCEDURES

For those matters not covered by the Constitution and Bylaws of the Illinois State Medical Society, Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for conduct of meetings of the House of Delegates, Board of Trustees and all councils and committees.

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1985-1986

Policy Manual of the Illinois State Medical Society

Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience.
Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy.

This manual shall be a guide for officers, AMA delegates and alternate delegates, trustees, committee chairmen and headquarters staff to the stand taken by the House of Delegates of the Illinois State Medical Society on all issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its next meeting for action. The House may:

(1) approve, amend, or reject—
(2) refer the statement to the Board for reconsideration and subsequent report—
(3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House must be presented in resolution form. A member of the Illinois State Medical Society may propose policy by requesting any delegate to submit an appropriate resolution. The Policy Committee will develop policy statements from actions of the House of Delegates and, after approval by the Board of Trustees, the statements will be published in this Policy Manual.

Temporary policy between meetings of the House is determined by the Board. Committees may request Board consideration at any time.

Established policy must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic process.

Professional Policies

Abortion

The decision to perform an abortion is a medical matter to be determined by agreement between the patient and the physician. Abortions must be performed in conformance with state and federal law and current medical standards, and when so performed shall not be considered unethical. Physicians shall not be required to perform or participate in an abortion by hospital regulations or any other institutional requirement.
(Amended, 1980 Annual Meeting)

Abuse and Neglect of the Elderly

Physicians, nurses and other health care personnel are reminded to be aware of possible instances of abuse and neglect of the elderly and are encouraged to report suspected cases appropriately.
(1982 Annual Meeting)

Acupuncture

Acupuncture is a surgical procedure and its practice shall be limited to physicians licensed to practice medicine in all of its branches and to dentists.
(1975 Annual Meeting—Reviewed by Board 1980)

Advertising, Physician Professional

See appendix for state law on physician advertising.

(Amended 1985 Annual meeting)

Alcoholism

Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity, by progression, and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational or social adjustments as a direct consequence of persistent and excessive use of alcohol. Insurance companies should include appropriate coverage for alcoholism. Physicians and their hospitals are encouraged to actively participate in providing services for alcoholics.
(Amended, 1980 Annual Meeting)

Alcoholism Education

The Illinois State Medical Society supports the concept that medical schools and hospital training programs should expand instruction of students in the treatment of acute and chronic alcoholism, as well as its cause and prevention; that physicians and recognized community service agencies should enlarge their services to include treatment and counseling of alcoholics and their families, and, where appropriate, collaborate with recognized alcohol treatment programs; that education programs aimed at alcohol abusers who are drivers should be encouraged, and legal restrictions should be continued to prevent them from holding drivers' licenses; that education of the public (at all age levels) regarding the nature of alcohol and its physiologic and psychologic effects, as well as socioeconomic impacts, should be encouraged.
(Amended, 1980 Annual Meeting)

Ambulance Services

All ambulance services should meet minimum standards as established by appropriate authorities in the field. ISMS should offer its expertise and work to ensure that ambulance services meet these standards.
(Amended, 1980 Annual Meeting)

Anaphylactic Reactions to Insect Stings

ISMS favors development of mechanisms to allow the availability of epinephrine, through appropriately trained persons, upon the prescription of a physician.
(1981 Annual Meeting)

Animals in Research and Education

The Illinois State Medical Society endorses the position that research and medical education, which involves the use of animals, is necessary to enhance the medical care of the public.
(1983 Annual Meeting)

Assessments

Medical staffs are reminded that hospitals do not have the privilege or the right to make compulsory assessments on individual members of the medical staff for building funds on other hospital programs, nor to demand an audit of staff members' personal financial records as a requisite for staff appointments.
(Amended, 1980 Annual Meeting)

Athletic Performance, Inappropriate Use of Procedures to Improve

The Illinois State Medical Society opposes the use of such items as, but not limited to, hormones, drugs and blood transfusions solely to improve athletic performance.
(1985 Annual Meeting)

Athletic Programs

The medical profession should provide input into the structuring of athletic programs in an effort to minimize physical injuries and inappropriate emotional stress and to insure proper treatment.
(Amended, 1980 Interim Meeting)

Audits and Surveys

ISMS recognizes the necessity of audits and surveys to review the appropriateness of medical services rendered. However, respect for personal privacy and confidentiality must be maintained with utmost priority under all circumstances. Additional, local medical staff audits and determinations as to management must be respected. In this regard, ISMS recognizes audit processes as performed by organizations who have demonstrated compliance with the aforementioned principles. In contrast, audits and surveys not performed by recognized organizations, or those performed in violation of the above principles, will not be condoned.
(Amended, 1980 Interim Meeting)

Autopsies

Because the autopsy has public health and educational benefits for medical science, the family of the deceased individual and the public at large, ISMS encourages its members to seek family approval for the postmortem examination in all cases of death.
(Amended, 1984 Annual Meeting)

Birth Control

The preventive medicine approach to the problem of unwanted pregnancies should be encouraged through family life education in the schools, wider dissemination of family planning information, including birth control information and devices, and encouragement of research in population control methods.
(1971 Annual Meeting—Reviewed, 1980)

Blood Availability

Since the use of a replacement or penalty fee has been eliminated in this state, ISMS encourages component societies to promote the public's full acceptance of the concept of truly altruistic blood donation and community responsibility.

The Illinois State Medical Society and its component societies should strongly encourage hospitals and any other facilities to affiliate with a regional blood replacement center in their areas.

The Illinois State Medical Society and its component societies should assist appropriate organizations in establishing a regionally coordinated blood banking system throughout the state and areas contiguous to the state.
(Amended, 1985 Annual Meeting)

Blood Services

Inasmuch as blood services affect the entire community, the county medical society should be encouraged to become involved and should have input in blood bank activities serving its county.

The Illinois State Medical Society will attempt to educate physicians and their patients through its publications regarding the inability of contracting AIDS by donated blood. "Designated blood donations" are an inappropriate means of dealing with the AIDS problem and inordinately tie up blood supplies.
(Amended, 1984 Annual Meeting)

Cardiopulmonary Resuscitation

ISMS encourages basic cardiac life support training in Illinois high schools.
(1981 Annual Meeting)

CPR and First Aid Training for Health Club Employees, Mandatory

ISMS endorses the concept that persons responsible for monitoring or instructing others in health and fitness facilities be certified in basic cardiopulmonary resuscitation.
(1984 Annual Meeting)

Child Abuse

ISMS urges all state health agencies and family service agencies which become involved in child abuse cases, to conduct, promptly, necessary investigation of the family environment prior to the release of the child for return to the same home where the abuse occurred.
(1981 Interim Meeting)

Child Safety Restraints

ISMS supports and encourages public education and legislation promoting child safety restraint use (infant and toddler car seats) and encourages physicians and others to discuss their benefits with all parents. Physicians are encouraged to learn about important safety features which have proven effective.
(1981 Interim Meeting)

Chronic Care Patients

The Illinois State Medical Society encourages medical schools and residency training programs to develop curricula addressing the issues of utilization of community resources and the strategies for dealing with the long-term medical, rehabilitation and social needs of chronic care patients.
(1984 Annual Meeting)

Code of Ethics

The following Code of Ethics represents standards of conduct defining the essentials of honorable behavior for the physician. They are not laws.

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or those who engage in fraud or deception.
3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.
4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical service.
7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

(1981 Interim Meeting)

Confidentiality

Communications received in confidence by physicians from patients are privileged: the privilege is that of the patient and the physician is the guardian of the privilege and must not betray it. Current day social values dictate that privileged communication must be continued in accomplishment of the treatment of human illness. Section IV of the Principles of Medical Ethics states that: "A physician shall respect the rights of patients . . . and shall safeguard patient confidences within the constraints of the law." The Illinois State Medical Society re-affirms its belief in this principle and supports activities to guarantee continuation of privacy, while recognizing the need for collection of statistical data and enforcement activities in the public good.

The Illinois State Medical Society supports the concept of confidentiality of the doctor-patient relationship as it relates to the ambulatory patient record and will take an active role in uncovering any violation of the doctor-patient relationship by officials and personnel of review organizations and will take whatever steps necessary to eliminate the breach of confidence.

ISMS is in opposition to the use of the Social Security number as a universal number identifier.

(1976 Interim Meeting—Reviewed, 1981)

Continuing Education

The Illinois State Medical Society shall continue its strong support of voluntary continuing medical education in Illinois and the intrastate accreditation of quality CME programs. Continuing education is one of the basic functions of the Illinois State Medical Society, which is committed to scientific advancement, humanization of medicine, and development of cooperation and rapport with the public. The Society shall continue to support the multifaceted approach to continuing medical education as now endorsed by the Illinois Council on Continuing Medical Education.

ISMS will act as an accrediting agency under the policies of the Accreditation Council for Continuing Medical Education as established by the organizations comprising the Council for Medical Affairs. The Illinois State Medical Society should have a primary role in accrediting of quality continuing medical education programs in order to assure that members have access to CME opportunities.

Physicians are encouraged to analyze their individual learning needs before registering for CME courses.

Financial support for the Illinois Council on Continuing Medical Education is provided by the Board of Trustees of ISMS. ICCME shall prepare an annual financial report for the House of Delegates including (a) major sources of income; (b) major categories of expenditure and (c) the budget for the year in which the House is meeting.

The Society's Executive Committee is authorized and directed to (1) act in its role as corporate members of ICCME to fulfill the adopted purposes of ICCME; (2) exercise the House of Delegates' prerogatives regarding ICCME between meetings of the House, and (3) report its activities as corporate members of ICCME to each annual meeting of the House.

All members should be encouraged to participate in the AMA Physician Recognition Award, as presently constituted, or its equivalent.

Sponsors of continuing medical education courses should provide full disclosure of materials, methods, objectives and evaluation procedures of offered courses. Accrediting body and category of credit should be stated.

(Amended, 1984 Annual Meeting)

Cost Containment

ISMS endorses the Voluntary Effort of American physicians and hospitals as responsible private sector activity to restrain hospital costs without arbitrary limits or governmental intervention, and it endorses the AMA president's call for physicians to help moderate care costs.

ISMS supports the concept of voluntary planning. ISMS should continue monitoring of planning legislation as to costs, benefits, and effectiveness; and encourage establishment of equitable techniques for administration of federal requirements. ISMS opposes imposition of the public utility type of regulation of the medical profession, whether institutional providers or private physicians. Certificate of need, as a cost containment mechanism, is a non-proven concept and requires continued evaluation.

"Decertification" or conversion to other use of excessive facilities should be on a voluntary and trial basis before final implementation.

The development of appropriate policies and mechanisms that lead to continuity, coordination, and continuous availability of patient care, including appropriate professional preventive care and appropriate early-detection screening services, should be encouraged. The appropriateness of a service, test or treatment should be the primary factor in considering its necessity rather than the cost.

Regulatory systems to certify and monitor the performance of insurance carriers, mutual insurance companies and other organizations financing health care services should be established to assure fiscal responsibility and accurate representation of premium or capitation costs and benefits that will not restrict development of innovative approaches to benefit coverage.

(Amended, 1983 Annual Meeting)

Current Procedural Terminology

The Illinois State Medical Society endorses the American Medical Association's Current Procedural Terminology and encourages its use by Illinois physicians.

(1977 Annual Meeting)

Death, Legal Definition of

A determination of death is a medical diagnosis which must be made in accordance with accepted medical standards by a physician licensed to practice medicine in all its branches, which may be made when an individual has sustained either: (1) Irreversible cessation of circulatory and respiratory functions, or (2) Irreversible cessation of all functions of the entire brain, including the brain stem.

(Amended, 1981 Interim Meeting)

Death With Dignity

The Illinois State Medical Society will continue to oppose death with dignity, right-to-die and similar legislation, based upon what must necessarily be a private matter between physician and patient. If passage of such legislation is imminent, it must provide immunity from civil and criminal penalties for physicians who act in good faith and in accordance with accepted medical practice and must not require physicians to act in violation of their own personal beliefs, morals and conscience.

(Amended, 1981 Annual Meeting)

Diagnosis Related Groups

ISMS supports the concept that the individual hospital medical staffs' responsibility is to ensure that appropriate quality of care for patients shall not be compromised in the Diagnosis Related Groups (DRG) process.

(1983 Annual Meeting)

DRG Payments and Cost of Procedures

ISMS encourages hospitals to establish a mechanism whereby physicians will have ready access, upon admission of patients, to information about expected DRG payments and charges for hospital procedures.
(1984 Annual Meeting)

Disaster Control

All medical societies should cooperate with and contribute to disaster plans in their communities.
(Amended, 1980 Annual Meeting)

Discrimination Against Physicians

The quality of medical training is an appropriate concern in the recruiting and credentialing of physicians. However, it is inappropriate to discriminate against any physician because of national origin or geographic location of medical education.
(1985 Annual Meeting)

Drinking Age, Legal

A uniform national legal drinking age of 21 years should be established by all states.
(1984 Annual Meeting)

Drugs, Prescriptions

Prescription drugs may be dispensed only upon the authorization of a physician licensed to practice medicine in all its branches. Public health departments should not conduct drug dispensing and distribution programs without direct physician supervision of patients receiving medication.

Only those generic drugs which are actually bio-equivalent should be included in the Illinois Formulary for the Drug Product Selection Program of the Illinois Department of Public Health.

ISMS urges IDPH to monitor and enforce proper generic drug substitution by pharmacists according to bio-equivalency based on the formulary.

The package insert labeling pharmaceutical preparations is a guide for the clinical application of the product and should not be used as an absolute standard limiting the practice of medicine.
(Amended, 1982 Annual Meeting)

Drunk Drivers

ISMS supports laws providing for stiffer sentencing of drunk drivers and encourages the judiciary to recommend rehabilitative treatment as an additional means of dealing with people convicted of driving while under the influence of alcohol.
(1981 Interim Meeting)

Electromyoneurographic Procedures and Examinations

Clinical electromyoneurographic procedures and examinations, which inherently involve medical interpretations, descriptions of findings, and rendering of diagnostic opinions, should be performed only by physicians licensed to practice medicine in all its branches and trained in these procedures.
(1976 Annual Meeting—Reviewed by Board, 1981)

Emergency Medical Care, Provision of

Emergency care should be provided regardless of the ability of the patient to pay. Physicians should be aware of the protection afforded them by the Good Samaritan provisions of the Illinois Medical Practice Act.

The Illinois State Medical Society encourages the State of Illinois and the business community to provide an emergency medical kit and qualified individuals for the administration of appropriate emergency care at functions where a very large number of individuals are present.

Insurance plans which cover emergency medical services should pay for such services regardless of where they are rendered.
(Amended, 1983 Annual Meeting)

Ethics

It is ethical for physicians to associate professionally with whom they wish, acknowledging always that there is no compromise on the historically noble goals of honesty, competence, compassion, respect for dignity, furtherance of knowledge, safeguarding of confidence and service to mankind, and with due regard to modern medical science.
(1979 Interim Meeting)

Examinations

All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local county medical society in a single instance or for a specific purpose.

This general statement does not apply to the industrial or occupational health physician in his in-patient activities.
(1966 Annual Meeting—Reviewed by Board, 1980)

Experimental Medical Procedures

With respect to experimental medical procedures, physicians must adhere to and affirm the following:

- Accepted ethical standards;
- The codified regulations of the Department of Health and Human Services as specified in Title 45 USC, Sec. 46;
- Appropriate Illinois statutory or regulatory requirements.

(Amended, 1981 Annual Meeting)

Eyes

Only physicians licensed to practice medicine in all its branches are qualified to prescribe or use eye medications; only such physicians should continue to be the primary entry-point for eye care. ISMS vigorously opposes any attempt in Illinois to give optometrists a license to prescribe or use medications or to serve as a primary entry-point in the provision of eye care.
(1976 Annual Meeting—Reviewed by Board, 1980)

Fees, Informing Patients of

Where feasible and desirable, physicians should provide patients with information regarding fees and, where practicable, discuss this information prior to providing care.
(1984 Annual Meeting)

55 M.P.H. Speed Limit

The Illinois State Medical Society opposes an increase in the 55 mile per hour speed limit.
(1981 Annual Meeting)

Firearms

The Illinois State Medical Society supports the right of counties or municipalities to enact ordinances restricting the ownership, possession, purchase, sale, transport or transfer of firearms or firearm ammunition. It opposes any state legislation in Illinois that would prohibit the enactment or enforcement of county or municipal ordinances restricting the ownership, purchase, sale, transport or transfer of firearms or firearm ammunition.
(1982 Annual Meeting)

Foundations for Medical Care

The Illinois Foundation for Medical Care is a not-for-profit corporation established to provide physicians with leadership roles in modifying health care delivery in their communities, thus assuring quality care at reasonable cost.

The Illinois Foundation for Medical Care is completely accountable only to the House of Delegates, through the Board of Trustees of ISMS, and to each component society of ISMS.

Establishment of autonomous county and/or multi-county foundations under the sponsorship of local medical societies is encouraged and, together, local and state foundations shall provide a mechanism through which foundation-sponsored programs can be developed and administered throughout the state.

The Illinois Foundation for Medical Care is authorized to investigate and, if economically feasible, to implement programs for supporting physician organizations endorsed by constituent medical societies. Such support is to be in the areas of data needs and other specialized activities, such as statewide co-ordination, statistical analysis, co-ordinated negotiations and support of related state level organizations, utilizing public, governmental or private funds to reimburse the foundation for such activities. Specifically, the IFMC Board is authorized to investigate the feasibility of becoming a state-wide support center for physician organizations endorsed by constituent medical societies

and to provide administrative support, data processing and specialized services to such physician organizations.
(1977 Interim Meeting)

Freedom of Choice

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the patient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice. All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.

ISMS supports the concept of second opinion—only via the usual and customary referral pathways guaranteeing the free choice of physicians.
(1976 Interim Meeting—Reviewed by Board, 1981)

Governmentally Supported Health Facilities

ISMS should not facilitate the development of governmentally-supported Health Maintenance Organizations or similar practice alternatives which would be discriminatory against the private or group practice of medicine.
(1978 Annual Meeting)

Health Care Costs

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

ISMS encourages its members to be aware of the cost of hospital services, supplies and drugs and encourages physicians to receive and review the hospital bill of each patient he hospitalizes as a voluntary step toward cost containment of health care.

ISMS is unalterably opposed to governmental control of hospital costs and physicians' fees and reaffirms its faith in the private enterprise system which has made the United States great and strong and which seeks to make health care available to everybody.

The Illinois State Medical Society encourages cost sharing by patients in all medical care reimbursement plans.
(1977 Interim Meeting)

Health Careers

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in paramedical fields shall be provided with all pertinent information.
(1967 Annual Meeting—Reviewed by Board, 1980)

Health Insurance, Governmental Programs

The Illinois State Medical Society is opposed to compulsory governmentally-mandated national health insurance plans and will continue to point out its dangers and disadvantages to the public, including those in which quality of care is compromised.

It is opposed to national compulsory catastrophic health insurance.

Governmental health insurance benefits for mental illness should be comparable to benefits for any other medical condition.

Governmental health insurance programs providing reimbursement for medical services under the direction of practitioners other than doctors of medicine or osteopathic medicine should establish a separate category for such reimbursement, with separate payment, and be optional to the insured.

ISMS will actively oppose any state or federal legislation which proposes reimbursement under health insurance programs of psychologists, social workers or any group of individual practitioners without medical supervision.
(Amended, 1979 Interim Meeting)

Health Insurance, Voluntary Plans

ISMS supports private, voluntary catastrophic health insurance, including freedom of choice of physician. Fixed fee schedules should be recognized as indemnification to the patient and not necessarily payment in full.

The Illinois State Medical Society supports the concept of increased insurance coverage for ambulatory diagnostic tests.

It supports the policy of a tax credit or deduction for the premium expense of catastrophic medical insurance and endorses the principle that, under federal rules and regulations, the costs and premiums for health care, whether incurred directly by an individual or conferred as an employee benefit, should be equally deductible.

Inasmuch as the fee coverage by insurance plans may not cover the full fee of the physician, the physician is encouraged to develop a prior agreement with the patient, such as the "Statement of Understanding." This will outline to the patient his individual responsibility for the physician's fee.

When insurance benefits are assigned to a physician by a patient, care should be exercised by the insurance company, or its agent, in seeing that such wishes of a patient are followed. If an error is made by the insurance company, or its agent, and payment is made to the patient, the insurance company is urged to admit its error and pay the physician as it was originally directed to do. Under such circumstances, recouping of the money from the patient should be the responsibility of the insurance company, or its agent, that committed the error and not the responsibility of the physician.

ISMS objects to third party carriers interfering with the practice of medicine and the patient-physician relationship by:

- Implying to patients that physician's charges above insurance benefit allowances are excessive;
- Suggesting to physicians that insurance company reimbursement amounts be accepted as payment in full;
- Suggesting that physicians perform alternative surgical procedures;
- Instituting utilization review of hospital patients in the private sector which by-passes local physician review mechanisms;
- Discriminating against the physician who does not have a separate contractual relationship with the carrier and inhibiting the patient's free choice of physician.

ISMS endorses long-held principles that:

- A contractual relationship that exists between a patient and a third party does not involve the physician (unless the physician has agreed to such involvement); and
- The third party is not involved in the contract existing between the patient and his/her physician (unless such involvement has been agreed to by both patient and the physician).

(Amended, 1982 Annual Meeting)

Health Maintenance Organizations

Every insurance identification card for a health maintenance organization should have the designation, "HMO," clearly printed on the front of the insurance card, along with the warning that unauthorized services may not be reimbursed and along with a 24-hour telephone number which can be called for payment approval in the event of an emergency.
(1982 Interim Meeting)

Health Planning

ISMS supports health planning on a local and voluntary basis with input by a significant number of physicians licensed to practice medicine in all its branches. Planning and implementation of the plan (regulation) are two different processes and should be kept separate and distinct.
(Amended, 1982 Annual Meeting)

Health Screening by Allied Health Personnel

Health evaluation, to be adequate, must include a physical examination only by or under the direct supervision of a physician licensed to practice medicine in all of its branches with physician interpretation of the appropriateness and reliability of various screening procedures used.
(1974 Annual Meeting—Reviewed by Board, 1980)

Health Systems Agencies

The Illinois State Society supports legislative activity by the American Medical Association repealing the Federal Health Planning Act, Public Law 93-641 and Public Law 96-79 as amended. As an interim measure, ISMS will seek legislative amendment in Congress or an administrative exemption removing those portions of the Health Plan-

ning Act which impose penalties on states not in compliance with federal SHPDA designated criteria.
(1981 Annual Meeting)

HSA Fund Solicitation

The Illinois State Medical Society is opposed to outside fund solicitation by Health Systems Agencies; for such practices may affect the objectivity of the organization.
(1980 Annual Meeting)

Hearing Disorders

Physicians licensed to practice medicine in all its branches remain the primary entry point for the care of patients with hearing impairment.
(1977 Annual Meeting—Reviewed by Board, 1984)

Hospices

A hospice is a centrally administered program of palliative and supportive services providing medical, social, psychological and spiritual care for terminally ill persons and their families. Services are provided by a medically-supervised, interdisciplinary team of professionals and volunteers. Care is offered 24 hours a day, 7 days a week, through either in-patient settings, home care or a combination of both. Bereavement counseling is provided for the survivors.
(1981 Annual Meeting)

Hospital and Medical Staff Committees

A hospital's medical staff should be an autonomous, self-governing body whose members participate in the activities of medical staff and hospital committees. However, physicians should distinguish between committees where the hospital gives the staff authority and responsibility and those where the hospital has full responsibility. Medical staff committees should be those composed solely of members of the medical staff and concerned with the quality of medical care. Hospital committees should be viewed as those created for some general hospital function and composed mainly of hospital personnel, that may or may not include medical staff members.
(1982 Interim Meeting)

Hospital—Medical Staff—Management Relationship

Any proposal or arrangement between institutional management and medical staffs should not conflict with the Principles of Medical Ethics or abridge the property right endowed upon the individual physicians by the Illinois Department of Registration and Education. The practice of medicine is the physician's legal prerogative and responsibility. To insure the quality of medical care, each hospital has the obligation to cooperate with and assist its medical staff in implementing procedures by which the quality of medical care in that hospital may be maintained by and through its medical staff.

ISMS is opposed to hospital actions which unilaterally stipulate that professional liability insurance is a prerequisite for membership on a medical staff. The hospital medical staff and only the medical staff should establish minimum limits of professional liability insurance coverage for their own medical staff. If a hospital proposes to require evidence of professional liability insurance as a condition of membership on the medical staff, such condition should be in accord with rules and requirements as established by the organized medical staff of the hospital in cooperation with the hospital board of trustees. To protect their assets, members of the hospital medical staff should be assured of the adequacy (scope and amount) of professional liability coverage carried by the hospital as a reciprocal disclosure between the staff and hospitals.

Results of recertification examinations should not be the sole criterion used by hospital governing bodies and hospital medical staffs in the granting of clinical privileges.

ISMS recognizes it is the right and duty of 1) a medical staff organization to evaluate the credentials of all applicants for medical staff privileges, according to objective, predetermined criteria of acceptability and 2) the hospital governing body to grant privileges to those applicants found acceptable and desirable as members of the medical staff.
(Amended, 1985 Annual Meeting)

Hospital Medical Staff Privileges

Members of a medical staff should receive due process as spelled out by the bylaws of the medical staff before their medical staff privileges can be terminated. The Illinois State Medical Society shall support physicians in their right to continue to practice in a community or hospital as long as they follow the bylaws of the medical staff and maintain a high quality of medical practice to their patients unless good cause can be shown that continuation of the physician in practice is not in the best interest of his/her patients.

A physician's hospital privileges should be based on clinical competency and quality of care.
(Amended, 1985 Annual Meeting)

IDPA Drug Manual

ISMS approves the concept that pharmaceutical products for inclusion in the IDPA Drug Manual be based on therapeutic effectiveness rather than cost. While ISMS members will continue to be cost conscious in all aspects of medical care, this care must be based upon therapeutic considerations and bioequivalence.
(1981 Annual Meeting)

Immunization Programs

Illinois residents should be provided access to all medically indicated immunization. Physicians are requested to provide this protection or to encourage the local public health agency to perform this function, and to encourage enforcement of current immunization laws. In addition, physicians should be encouraged to participate in epidemiological studies (especially as related to "search and destroy" methods for communicable diseases) which have been endorsed by the local or state medical society.

ISMS continues to support the need for physical examinations of, and updating of immunizations for school children in the State of Illinois on school entry, at 5th grade and 9th grade levels, in keeping with preventive medicine measures presently in existence in the state. Measures to assure compliance of the school health mandates by school districts in Illinois should be maintained.

Every school district should be consulted by health departments planning any mass immunization campaign. In counties where there is no public health department, the Illinois Department of Public Health should contact either the county medical society or local physicians (whichever is appropriate) for coordination of the immunization program.

The Illinois Department of Public Health or the Illinois State Medical Society should institute whatever is necessary, including appropriate state indemnification or "exemption from liability" legislation, to assume or alter the liability responsibility during any mass immunization program.

If private facilities are utilized during a mass immunization campaign, normal reimbursement procedures may be employed, but no charge shall be made for the cost of vaccine paid for by the federal government.
(Amended, 1984 Annual Meeting)

Impaired Physicians

The Illinois State Medical Society and its individual members should recognize the importance and need to promote, support and participate in state, local and hospital activities to prevent, recognize and overcome impairment among medical students, residents and practicing physicians.
(1985 Annual Meeting)

Indigent, The Care of the

The Illinois State Medical Society reaffirms organized medicine's commitment to provide care to those who need medical care, regardless of their ability to pay for it.

However, personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.
(Amended, 1982 Interim Meeting)

Infants Born with Disabilities, Care and Treatment of

The Illinois State Medical Society urges all Illinois medical staffs to develop and conduct educational programs for their members involved in the care of handicapped infants, regarding advances in such care, as well as laws and regulations affecting the delivery of these infants.
(1984 Annual Meeting)

Informed Consent

ISMS endorses the position that disclosures made to patients conform to the general practices of the medical profession in the same or a similar community or locality, which are disclosures that a reasonable medical practitioner would make under the same or similar circumstances.

ISMS opposes legislative definition of informed consent.

However, it favors enactment of legislation providing that consent for furnishing medical treatment to an adult patient, who is not capable of consenting, may be given or refused by the patient's competent spouse, parent, adult child or adult sibling.
(Amended, 1982 Interim Meeting)

Insanity as a Defense

ISMS supports the concept that a person may be found innocent of a crime by reason of having severe mental illness or retardation.

For a person to use insanity as a defense, the severity of the person's mental condition should be shown to exhibit an inability to know the nature of his conduct at the time of the offense, and that he was unaware that the act was wrong and personally or socially destructive to himself or someone else.

Testimony by medical experts on the nature of a person's mental condition should be limited to the diagnosis, mental state and motivation of an individual and not on whether the person is "sane" as determined by legal standards.

A person found innocent by reason of insanity should be provided treatment and ongoing supervision to ensure the public is protected, and when psychiatric treatment can no longer help an individual, who is still considered dangerous, that person should be transferred to a nonmedical facility for further supervision.
(1985 Annual Meeting)

Joint Commission on Accreditation of Hospitals

A "physician" (doctors of medicine or doctors of osteopathy) is defined as one who by education, training, experience, and licensure is able to practice medicine in all of its branches. ISMS encourages the Joint Commission on Accreditation of Hospitals to require greater than a majority of fully licensed physician membership on the medical staff executive committees in acute care general hospitals. ISMS urges JCAH to recognize the importance of the medical staff in credentialing and in monitoring the quality of care in the hospital and it encourages the development of the appropriate environment within the hospital so that both the medical staff and limited licensed practitioners may work together for the best interests of the patient.
(1983 Annual Meeting)

Laboratories

All laboratories providing medical data should be under the direct supervision of a physician currently licensed to practice medicine in all its branches.

The Illinois State Medical Society opposes any attempts to change the Illinois Clinical Laboratory Act by exempting commercial laboratories or free-standing laboratories and clinics operated by hospitals from meeting the standards of this act.
(Amended, 1985 Annual Meeting)

Manipulative Casting of Congenital Deformities of the Extremities

Manipulative casting of congenital deformities of the extremities, whether performed in the office or hospital, is considered a surgical procedure.
(1981 Annual Meeting)

Marijuana

ISMS does not endorse the legalization of the possession or use of marijuana.

Since the medical and psychiatric knowledge concerning the short-term and long-term effects of cannabis is very limited, medical research should be supported by public and private resources of the State of Illinois.
(1976 Annual Meeting—Reviewed by Board, 1980)

Medical Diagnosis and Treatment

While the Illinois State Medical Society recognizes the interests of third parties in patient care, it categorically maintains that prognosis and length of treatment must always be individualized to the patient, the diagnosis, and community standards for medical care.
(Amended, 1980 Annual Meeting)

Medical Education—Schools

The Illinois State Medical Society supports development of innovative programs in medical education maintaining a firm foundation in the basic sciences.

It favors admission of students into medical schools on the basis of their ability to be good medical students and physicians.

It supports the philosophy that all medical education accepted for licensure to practice should be comparable.

Graduates of state medical schools are encouraged to practice medicine in Illinois and ISMS will utilize its organizational structure to develop positive incentives.

ISMS encourages primary care residency programs to establish educational activities in the rural and underserved areas of Illinois.
(Amended, 1982 Interim Meeting)

Medical Examiners

ISMS favors a medical examiner system throughout the state in preference to a coroner system, wherever practical.
(1971 Annual Meeting—Reviewed by Board, 1980)

Medical Liability Insurance Premiums

The Illinois State Medical Society supports the concept that premium schedules for medical liability insurance should be based on the actual cost and risk of providing that insurance to each individual group or category.
(1979 Annual Meeting)

Medical Psychotherapy

Medical Psychotherapy is a medical procedure for the treatment of mental and physical ailments or illness. It involves verbal and non-verbal communications with the patient, and always includes continuing medical diagnostic evaluation and drug management as indicated. Medical psychotherapy may be performed only by a physician licensed to practice medicine in all of its branches.
(Amended, 1980 Annual Meeting)

Medical Representation in Government Planning

Unless physicians appointed to the boards and committees of other organizations are nominated by their local county medical society, such physicians shall not be considered "representative" of the medical community.

ISMS supports the concept that when federal funds are available to the states, physicians should actively participate in the distribution of these funds.
(Amended, 1982 Interim Meeting)

Medical Staff Participation in Accreditation Activities

Medical staff of a hospital should cooperate to achieve JCAH accreditation of their hospital.
(1982 Interim Meeting)

Medical Staff Participation in Hospital Cost Containment Efforts

Physicians on a hospital's medical staff should encourage and cooperate in efforts to see that hospital care is delivered in the most effective manner without compromising quality.
(1982 Interim Meeting)

Medical Staff Relationship with County Medical Society

County medical societies are encouraged to form standing committees composed of medical society officers and representatives of all hospital staffs in their areas to guarantee a free exchange of information between the medical society and hospital staffs related to activities of hospitals, medical organizations and official and voluntary health related agencies in their community.
(1982 Interim Meeting)

Medical Supplies, In-Flight

The Illinois State Medical Society encourages air carriers to equip planes with an emergency kit on each flight and that flight crews be instructed in cardio-pulmonary resuscitation procedures.
(1982 Interim Meeting)

Medical Testimony, Expert Witnesses

An expert medical witness is defined as a physician licensed to practice medicine in all its branches having a basic educational and professional knowledge as a general foundation for testimony and, in addition, having special expertise, current personal experience, practical familiarity, and technical knowledge of the problems that are being considered, as well as alternative forms of treatment, and is currently active in the practice of the medical subject under discussion.

Any physician licensed to practice medicine in all its branches who functions as an expert witness, must satisfy the definition of an expert witness that the definition be a matter of policy, and that it be considered unethical conduct on the part of any physician appearing as an expert witness who does not meet this standard.
(1977 Annual Meeting—Reviewed by Board, 1981)

Medical Testimony, Impartial

The ends of justice are served when impartial medical witnesses are available to the judiciary. The ISMS supports this concept and offers its assistance in the provision of impartial medical testimony.
(Amended, 1980 Annual Meeting)

Medicare Assignments

The Illinois State Medical Society supports the concept that Medicare payments be made directly to physicians who choose to accept Medicare assignments. When a Medicare payment is incorrectly made directly to the patient, Medicare should make full payment to the physician who has chosen to accept Medicare assignments as soon as the error is verified.
(1980 Interim Meeting)

Mental Health

The Illinois State Medical Society strongly opposes a double standard of care in state hospitals.

The Department of Mental Health and Developmental Disabilities (DMHDD) should adopt a firm policy for the continuing education of physicians employed by its various mental health centers, allocating state funds necessary to provide high-quality continuing medical education relevant to the needs of these physicians.

Each constituent county society should cooperate fully with and support local units of the DMHDD in their patient care efforts, specifically seeking to encourage:

1. Local general hospitals to accept mental health patients who can be helped by short-term treatment, leaving to state institutions the responsibility for such chronic and long-term cases which local hospitals cannot presently handle.
2. Local general hospitals and practitioners to retain in their own care those geriatric patients who have ailments of primarily a physical nature.
3. Local physicians, local hospitals, and local skilled nursing facilities to provide primary and secondary care for psychiatric problems to the extent possible; given facilities and physician-time available.
4. Arrangements for emergency mental health care, *i.e.*, crisis intervention, to be available areawide.

All physician or other health service provided to the DMHDD, other than that by fulltime employees, should be on the same fee-for-service basis as any other medical service which is paid by the patient or third party insurer.

Involuntary psychiatric hospital certification, initial or subsequent, must without exception remain the responsibility of a physician licensed to practice medicine in all of its branches and a physician licensed to practice medicine in all of its branches should be required to certify the discharge of any patient from a psychiatric institution.
(1977 Annual Meeting—Reviewed by Board, 1981)

Motorcycle Helmets

All Illinois physicians should encourage their patients who use motorcycles to wear protective helmets, pointing out the efficacy of such helmets in preventing death during collisions.
(1982 Annual Meeting)

Multiphasic Screening

Multiphasic screening tests (including brief physical examination and multiple automated laboratory tests) are accepted procedures for health evaluation when carried out in a scientific manner and in conformance with laws of the State of Illinois and regulations of the Department of Public Health. The persons participating in or sponsoring these activities should be advised that: (1) Abnormal findings do not necessarily indicate a disease exists; such a determination must be made by a physician; (2) The absence of abnormal findings does not necessarily indicate the patient is free of disease; and (3) That such screenings should be done under the guidance of local medical societies or other recognized medical authorities.
(Amended, 1980 Interim Meeting)

Newborns, Prenatal Development of

The public concern about the macroenvironment's effects on human health should be expanded to include equal concern for a healthy intrauterine environment for the prenatal period of development of each child.
(1984 Annual Meeting)

Nurses-Shortage

A severe shortage of graduate nurses continues to imperil the provision of quality patient care. The ISMS supports all forms of qualified nursing education and urges that all such schools be encouraged to remain in operation.
(1970 Annual Meeting—Reviewed by Board, 1980)

Nursing Homes

Every patient receiving long-term nursing care should have an attending physician who acknowledges his continuing responsibility in writing. Responsible parties, preferably the patient or immediate family, should be urged to select a physician.
(1973 Annual Meeting—Reviewed by Board, 1980)

Nutrition

Proper attention to patients' complete nutritional status should be of concern to all physicians. Patient education in the field of nutrition should be a major priority.
(Amended, 1980 Annual Meeting)

Occupational Health

Occupational health is an essential ingredient of employee welfare. The continued adoption and development of occupational health programs in the private and public sectors should be encouraged.
(Amended, 1980 Interim Meeting)

Optometric Services

ISMS supports the concept that those performing optometric services in Veterans Administration facilities should be directly responsible to their respective departments of ophthalmology.
(1978 Annual Meeting—Reviewed by Board, 1984)

Patient Care Records and Their Availability

Patient care records contain privileged information of confidential nature. Such records are the property of the hospital, clinic or physician. Information contained therein is held in trust by the holder.

In the case of hospital records, patients, patients' attorneys or patients' succeeding physician, upon written patient authorization, have the right of access to hospital records, the ability to review and the right to

copy or receive copies. Hospitalized patients may be afforded access to their records upon discharge but not during hospitalization. This access is not afforded in case of psychiatric illness. In the case of nonhospital records, patients' attorney or succeeding physician, but not patients themselves, upon presentation of written patient authorization, have the right of access to said records, with the ability to review and the right to copy and receive copies.

Upon receipt of proper, written authorization from the patient, a copy abstract or summary shall be provided, as required, to legally authorized recipients of such record.

Patient records are utilized by official committees of organized medical staffs to accomplish scientific review, peer review or other patient care improvement. Reports and proceedings of such committees are confidential and shall not be disclosed to any person outside the purview of such committees. ISMS will take all appropriate action to preserve the confidentiality of records and activities of medical staff committees.

Pursuant to a subpoena for records, a physician is legally required to release medical records in the absence of a signed patient authorization. It is recommended that when records are released, a copy be maintained in the physician's file.

A reasonable charge for record copying service may be made.

Reference may be made 1979, Illinois Revised Statutes, Chapter 48, Section 138.8; Chapter 51, Sections 71, 73 and 101; Chapter 91½, Section 800ff.
(Amended, 1984 Annual Meeting)

Peer Review

See Chapter XII of the Bylaws.
(Amended, 1983 Annual Meeting)

Physician-Patient Relationship

The Illinois State Medical Society encourages voluntary health organizations to work with the available local medical communities in providing referral and treatment of cancer patients so that existing physician-patient relationships are not breached.
(1984 Annual Meeting)

Physician Records, Privacy of

The Illinois State Medical Society will take appropriate action to assure that no third party be granted access to the physician's own private medical practice business records, including copies of cancelled checks, cash disbursement journal, leases, contracts, or other confidential business records, without appropriate authority assuring due process.
(Amended, 1984 Annual Meeting)

Physicians

The term, "Physician," may only be applied to one who has equivalent qualifications of a "physician licensed to practice medicine in all its branches."
(Amended, 1981 Interim Meeting)

Physician's Assistants

The Illinois State Medical Society recognizes the physician's assistant as a trained health professional who can serve a proper function within the scope of his/her certification and under the direct one-to-one supervision of a physician.
(1980 Annual Meeting)

Prolonging Human Life

Any legislation which proposes statutory restrictions that can intrude into the relationship of the physician and his patient and which may interfere with the physician's ability to use his best judgment and training in caring for his patient is not in the best interest of either the patient or the public and should, therefore, be unrelentingly opposed.
(1976 Annual Meeting—Reviewed by Board, 1984)

Provider Organizations, Exclusive

ISMS should monitor the development of health maintenance organizations, IPAs, preferred provider organizations, and exclusive provider organizations in Illinois and have this information available to assist ISMS members in their relationships with these organizations.
(1984 Annual Meeting)

Psychosurgery

Psychosurgery refers to those surgical operations which irreversibly destroy brain tissue for the primary purpose of treating mental disorders. Psychosurgery does not include procedures undertaken to treat definable disease states such as tumors, epilepsies, aneurysms and chronic pain syndromes, nor does it include electrical stimulation of the brain, such as electroconvulsive therapy. Psychosurgery should not be performed without adequate documentation of indications, adequate consultation and reasoned consent.
(1975 Annual Meeting—Reviewed by Board, 1980)

Public Aid

The "chain of command and procedure" in handling problems arising in the field of public aid shall be from the county to the state advisory committee; then the state advisory committee shall assume the responsibility of making the medical program work and cooperating with the Illinois Department of Public Aid to maintain the best type medical care for the recipients of state aid.

The fees paid by state/federal programs to physicians should be based upon the usual and customary fee concept.

Because modern medical care frequently requires multispecialty medical management, including primary care physicians and specialists working together for the benefit of the patient, traditional fees for multispecialty care for Public Aid patients should be made available without extensive justification procedures.
(Amended, 1981 Interim Meeting)

Public Health Departments

Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts, including contributions by voluntary health associations, medical societies and other health-oriented groups.

Full-time modern local health departments adequately financed and staffed at the county or multiple county level are highly desirable and, if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support.

ISMS encourages and supports the development of local joint committees of county medical societies and county public health departments to review current and proposed public health projects.

ISMS encourages local health departments and component medical societies to delineate the roles of the public and private sectors in providing health and medical services to the community. The following should be considered: 1) coordination and facilitation of direct services which should occur in a manner to avoid duplication of available medical services; 2) the availability of private medical services; 3) the gaps in medical and health services that should be filled by public health activities; and 4) the socio-economic characteristics of the population to be served.
(Amended, 1980 Annual Meeting)

Rehabilitation

All physical rehabilitation activities should be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services.

Insurance carriers should be encouraged to include rehabilitation services in their contracts.
(Prior to 1965—Reviewed by Board, 1980)

Reimbursement of Ambulatory Services

Third party payors should be encouraged to provide coverage for ambulatory surgery and diagnostic procedures. Final medical decisions must remain in the hands of the attending physician. However, the Illinois State Medical Society supports the concept of maximum utilization of ambulatory surgical services consistent with the doctor's judgment of the facilities available.
(Amended, 1982 Annual Meeting)

Reimbursement for Medical Care of Psychiatric Illness

Medical care of psychiatric illness should be included in all health insurance policies.
(1980 Annual Meeting)

Reimbursement for Out-Patient Services

Third-party payors should be encouraged to provide coverage for outpatient diagnostic tests and surgery.
(1980 Annual Meeting)

Reimbursement for Treating Medicaid Patients

The Illinois State Medical Society approves in principle the concept of amending appropriate state and federal laws to provide physicians with the option of taking state and federal income tax credits or deductions in lieu of direct reimbursement for the treatment of Public Aid recipients.
(1981 Annual Meeting)

Reimbursement, Physician

It is desirable to afford maximum flexibility and latitude in creating an economic environment acceptable to the individual physician's right to choose which method of economic reimbursement for care that best suits the needs of that physician and his/her patients. Where appropriate, ISMS supports the right of physicians to seek payment from patients for the difference between the physician's charges and the amount of payment an insurance carrier pays. To the extent practicable, ISMS should strive to assist physicians in understanding alternative reimbursement systems, including but not limited to Usual and Customary or Reasonable (UCR).
(Amended 1985 Annual Meeting)

Relationship with Third Party Payors

ISMS should provide guidance, education, communications, and negotiations between the membership and third party payors.
(1980 Annual Meeting)

Seatbelt Use

The Illinois State Medical Society supports the voluntary use of seatbelts and other passenger restraint devices as effective methods of reducing injury and death in motor vehicle accidents. It supports state legislation requiring that all school buses be equipped with passenger safety restraints and other structural modifications to assure maximum impact safety.
(Amended, 1983 Annual Meeting)

Smoking

The Illinois State Medical Society, as a matter of policy, publicly adopts a vigorous stand against cigarette smoking because it is a major health hazard. The Society will work with other agencies inside and outside medicine to eliminate this contributory cause of death, disability and rising health care cost. ISMS will support appropriate legislative initiatives to communicate the risks of tobacco to all, particularly young people.

The Illinois State Medical Society is opposed to the sale of tobacco and tobacco products in hospitals and encourages medical staff action to make hospitals tobacco smoke-free, except for certain areas designated for smoking.

Physicians should refrain from smoking during professional patient visits. Exemplary abstinence during social contacts by physicians and their employees with the public in general is highly desirable. Literature and signs concerning the health hazards of smoking should be displayed in medical offices and other public places over which health care professionals have control.
(Amended 1985 Annual Meeting)

Surgery, Reconstructive

Reconstructive surgery is surgery which is intended to correct deformities caused by disease or accident.
(Amended 1985 Annual Meeting)

Surgery, Second Opinion for

Recognizing that the advisability of surgery or other special therapy can be a matter of opinion, the Illinois State Medical Society (1) reaffirms the right of the patient to seek a second opinion freely from any physician of his/her choice; (2) opposes the concept of mandatory second opinions or the imposition of financial penalties by a third-party payor for not obtaining a second opinion; and (3) supports the concept that, when a second opinion is required by a third-party payor, that second opinion should be at no cost to the patient.
(1979 Annual Meeting)

Third Party Intrusion Into Medical Judgment

Medical judgment and decision-making power of the treating physician must not be abrogated by third party payors. ISMS is opposed to any third party having the power of decision as to medical necessity of services and supplies, including hospitalization over and above the judgment of the treating physician.
(1978 Annual Meeting)

Tobacco Farm Subsidies

The Illinois State Medical Society opposes the subsidization or price supports of tobacco farming.
(1982 Annual Meeting)

Usual and Customary or Reasonable Reimbursement

The Illinois State Medical Society endorses the AMA policy on physician reimbursement, which supports only the usual and customary or reasonable concept, rather than any type of negotiated fee schedule.
(1979 Annual Meeting)

Veterans Administration

The Illinois State Medical Society continues to support the concept that a Veterans Administration hospital should only be concerned with the needs of those patients with service-connected disabilities.
(Amended, 1980 Annual Meeting)

Violence

The Illinois State Medical Society opposes the ready accessibility to hand guns without evidence of responsibility on the part of the possessor and urges strict enforcement of present federal, state and city laws and that the courts, as well as the legislature, impose maximum penalties on all offenders.

The Illinois State Medical Society will continue to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians, including the offering of rewards and other incentives in the solution of such cases.
(1978 Annual Meeting)

Workers Compensation

The Illinois State Medical Society advocates a single radiologic examination to satisfy the medical requirements at a given time in the course of a workers compensation injury.
(1982 Annual Meeting)

ADMINISTRATIVE POLICIES

AMA-ERF

The AMA-ERF contributions for Illinois graduates shall be distributed to the Illinois medical school from which the member graduated.

The contribution for the balance of the membership shall be distributed to Illinois medical schools in the same proportion as above.

Any member may over-ride this procedure and designate a school of choice by advising ISMS in writing.
(Amended, 1980 Interim Meeting)

Autonomy of County Medical Societies

In all areas, the county medical society shall be autonomous. Actions of any county medical society should conform with the Constitution and Bylaws of the Illinois State Medical Society.
(Amended, 1980 Interim Meeting)

Budgets—(see Financial Policies)

Committee Appointments

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Individual tenure on any committee should be limited to a maximum of five years of continuous membership.

Physicians appointed to Illinois State Medical Society committees must be members in good standing of this Society.
(1978 Interim Meeting)

Councils and Committees

It is the policy of the Board of Trustees to encourage evening or weekend meetings of councils and committees at convenient locations to improve membership involvement in council and committee activities.
(1981 Annual Meeting)

Disciplinary Action

The Illinois State Medical Society will immediately communicate any disciplinary action by the Department of Registration and Education to the appropriate county society.
(1980 Interim Meeting)

Dues Approval Procedure

All financial matters involving changes in dues, dues structure, allocation of dues, or levying of assessments in any such manner shall be distributed to all delegates and alternate delegates and to all presidents and secretaries of county medical societies at least thirty days prior to the convening of the House of Delegates.
(1980 Annual Meeting)

Dues Stabilization, Membership

The Illinois State Medical Society should 1) carefully consider the delicate balance of dues and membership and 2) maintain reasonable dues within the context of budgetary reviews and long-range planning in order to preserve medicine's strength by member involvement and participation.
(1985 Annual Meeting)

Election of AMA Delegates

Delegates to the American Medical Association should be elected from those having served first as alternate delegates.
(Amended, 1980 Annual Meeting)

Financial Policies

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) ISMS funds used by members campaigning for elections as AMA officers, trustees or members of councils or committees must be approved by the ISMS Board of Trustees before such funds are spent for election campaign purposes.

(4) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(5) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(6) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(7) In addition to fixed reserves, the development of a contingency reserve is desirable.

(8) All financial records shall be available at headquarters office, and may be examined by any member of the Society. A semi-annual summary of the financial statements of the Society shall be mailed to any county society secretary or delegate if requested. A projected budget for the next fiscal year shall be mailed to the members of the House of Delegates at least 30 days prior to the annual convention. These reports shall be in the format customarily used in ordinary corporate practice.
(1977 Annual Meeting)

Honoraria For Officers

The Finance Committee is instructed to evaluate annually the honoraria paid to ISMS officers and to recommend appropriate changes to the Board of Trustees for consideration and action, reporting any changes to the House of Delegates at its next session.
(1978 Annual Meeting)

Illinois Medical Journal

The Publications Committee, with approval of the Board of Trustees, has authority to carry out publication policy. The committee is responsible for screening proposed advertising copy and advertisers, as well as for direction of the editorial content.

ISMS asserts the right to first refusal of original papers presented at programs for which ISMS is primary fiscal sponsor.
(1981 Annual Meeting)

Individual Rights

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with the Society's basic philosophy.
(Prior to 1965—Reviewed by Board, 1980)

Informing the Membership

The membership of the Illinois State Medical Society shall have been properly informed when the following items have been accomplished:

1. Official notice in the *Illinois Medical Journal;*
2. Brief notice in Action Report, whenever possible, outlining the issue and calling attention to the *IMJ* article; and
3. A letter is sent to all county society presidents, secretaries and county executives.

(Amended, 1982 Annual Meeting)

ISMS Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.
(Prior to 1965—Reviewed by Board, 1980)

ISMS Candidates for AMA Positions

Selection and/or endorsement of ISMS candidates for positions on AMA Board, councils or major committees should be submitted to the American Medical Association by the ISMS Delegation, through its chairman, after consultation with the ISMS Board of Trustees or its Executive Committee, except when emergency action is necessary because of unexpected vacancies.

Nomination for appointments to subcommittees, ad hoc committees, other minor committees of AMA or as AMA representatives to certain outside agencies may be made directly by the Chairman of the ISMS Board of Trustees, after consultation with the Chairman of the ISMS Delegation, without specific approval of the full Board of Trustees or AMA Delegation. Such action shall be reported to the Board of Trustees and the AMA Delegation.

Upon receiving notice that an Illinois physician has been nominated for AMA position by an organization other than ISMS, the Chairman of the ISMS Board of Trustees, pursuant to the recommendation of the Chairman of the AMA Delegation, shall inform AMA only whether or not the nominee is a member in good standing of ISMS.
(Amended, 1981 Interim Meeting)

Legal Counsel

The legal counsel of the Illinois State Medical Society shall serve the Society at the direction of the Board of Trustees. Counsel shall respond to official inquiries from officers, trustees, committee chairmen and county medical societies. Such inquiries shall be channeled through the Board of Trustees.
(Amended, 1980 Annual Meeting)

Legislation

All matters presented to the House of Delegates or Board of Trustees pertaining to state or federal legislation shall be reviewed by the Governmental Affairs Council, which shall evaluate its potential impact on the society's current legislative efforts. The council shall submit its report to the Board of Trustees, which shall advise and recommend action to the House through the Chairman of the Board.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Governmental Affairs Council of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Governmental Affairs which shall work in close cooperation with any other society committee involved. The instigating committee should determine the content of the law and the Governmental Affairs Council primarily should consider relationship of the proposed legislation to the total legislative program.

Any council or committee recommending legislation to the attention of the Governmental Affairs Council must provide expert witnesses when called upon to testify before Senate and House committees in support of, or in opposition to, the legislation recommended by the council or committee.
(Amended, 1981 Interim Meeting)

Legislative Intrusion into Medical Judgment

The Illinois State Medical Society opposes any and all legislative efforts to interfere with physicians' judgment as to which procedures are appropriate and in the best interest of his or her patients and ISMS will work aggressively to oppose any legislation abridging the physician's prerogatives in this regard.
(1974 Annual Meeting—Reviewed by Board, 1980)

Mailing List

The use of the mailing list of ISMS members must be approved by the Board of Trustees.
(Amended, 1980 Annual Meeting)

Medical Representation in Government Planning

In health programs financed by government funding in an Illinois community, there shall be representation at the highest policy level by an official representative of the state society and the appropriate county medical society involved. Remuneration for services in above programs shall follow the policies of the Illinois State Medical Society.

Only those programs which have involved physicians at the local level in the planning and development stages shall be approved by ISMS.

Only physicians appointed to the boards and committees of other organizations who are endorsed by their local county medical society shall be considered "representative" of the medical community.
(1978 Interim Meeting)

National Library of Medicine

The Illinois State Medical Society supports the programs of the National Library of Medicine. Fees for subscribers should be based on the current accounting system rather than on total costs.
(1982 Interim Meeting)

Participation in Service Organizations

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.
(Amended, 1980 Interim Meeting)

Physician Recruitment Service

The Illinois State Medical Society shall coordinate activities connected with recruiting doctors to practice in Illinois. It shall maintain a Physician Recruitment Service to disseminate information about physician-short communities to doctors who have indicated to the service that they wish to relocate in Illinois. It shall take an active role with other organizations in Illinois conducting recruitment activities.
(1980 Annual Meeting)

Polls, Opinion

The Board of Trustees is responsible for ascertaining the opinion of members on critical issues facing the society. Periodic membership opinion polls should be considered as one means of ascertaining member opinion. However, the vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership since delegates are the duly elected representatives of their county medical societies and it is the responsibility of the delegates to determine the thinking of their constituents so that their voting will express this opinion. The majority opinion is expressed in the House of Delegates and it should be unnecessary to conduct a membership poll except under very exceptional conditions.
(1976 Interim Meeting—Reviewed by Board, 1982)

Press

In order to provide the public with prompt and accurate information on all health-related matters, all county medical societies are encouraged to cooperate with the local news media.

County medical societies are responsible for providing their local media with information concerning official county society statements or actions, and should serve as a source of information on health issues of local concern.

The state society is solely responsible for disseminating information on its official actions, statements or views of the Illinois State Medical Society on issues with statewide or national implications.
(1980 Interim Meeting)

Professional Liability

The Illinois State Medical Society endorses the concept of effective peer review in all matters related to the professional liability of physicians, including the right of individual physicians to appear before appropriate peer review committees responsible for this liability coverage.
(Amended, 1978 Interim Meeting)

Public Statements

Only officially designated persons may publicly speak for the society. The chairman of the Board of Trustees, at the request of the President, shall designate ISMS spokesmen.

Spokesmen should bear in mind that, as representatives of the society, they should refrain from expressing their personal views. Their public statements should be—to the best of their ability—in consonance with the society's policies and positions.
(1978 Annual Meeting)

Public Statements, Endorsements

No officer, member of the Board of Trustees, council or committee chairman or staff member is permitted (during his term of office or employment) to allow his name and ISMS title to be used in lists endorsing candidates for public office. No one shall use the official Illinois State Medical Society stationery for personal statements of any nature, including the endorsement of any candidate for public office.
(1980 Annual Meeting)

Reference Service

County medical societies should establish procedures for referral of patients seeking physician services. It is appropriate to announce the availability of such an activity via the news media as a public service. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved.
(Amended, 1980 Interim Meeting)

Resident Physician Membership

Each regular member of ISMS is encouraged to recruit at least one resident physician member every year, with the regular member providing assistance to the resident in completing the application process for membership.

The Governing Council of the ISMS Resident Physicians Section will serve in an advisory role for component societies planning resident participation at the local level.
(Amended, 1983 Annual Meeting)

Resident-Student Alternate Delegates to AMA

The Resident Physicians Section and the Medical Student Section shall recommend to the chairman and the secretary of the AMA Delegation the names of residents and students to be appointed to fill any alternate delegate vacancy on a temporary basis.
(1979 Annual Meeting)

Resolutions

Since the relationship between the Illinois State Medical Society and other voluntary physician membership organizations is the responsibility of the Board of Trustees, the Speaker of the House of Delegates shall refer to the Board any resolutions making reference to other voluntary physician membership organizations not affiliated with ISMS.
(1976 Interim Meeting)

Specialty Society Representation on ISMS Councils

For the improvement of communication and the discussion of problems of mutual interest and concern, closer liaison between specialty societies of medicine and the councils of the Board of Trustees is desirable.

Specialty societies represented on the Council on Affiliate Societies shall be invited to submit recommendations for appointment to ISMS councils. Persons so recommended shall be members of both ISMS and the specialty society making the recommendation.
(1979 Annual Meeting)

Uniform Health Insurance Claim Form

The Illinois State Medical Society supports the use of the Health Insurance Claim Form developed by the AMA Council on Medical Service by all insurance carriers and physicians.
(1974 Annual Meeting—Reviewed by Board, 1980)

Policy Manual Appendix

Statement of Understanding

(between patient and physician)

I agree that the determination of professional services to be rendered by my doctor and the fees to compensate him for these services are matters concerning my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his services, notwithstanding any contract I may have with any third party (be it an insurance company, employer, union, government, or the like). Neither my doctor nor I will permit any third party to determine what medical services I need or what fees the doctor should receive in return for these services. Any agreement that either of us may have with any third party shall not affect our doctor-patient relationship and the decisions relating to medical care and fees. Neither my doctor nor I, as his patient, are in any way bound by any contract the other may have with any third party.

State Law on Physician Advertising

The Illinois legislature passed a law to govern advertising by physicians which came into effect as of July 1, 1980. The text of Illinois law is reprinted below as a service to ISMS members.

4434. Advertising

§ 16.01. Any person licensed under this Act may advertise the availability of professional services in the public media or on the premises where such professional services are rendered. Such advertising shall be limited to the following information.

(1) Publication of the person's name, title, office hours, address and telelphone number;

(2) Information pertaining to his areas of specialization, including appropriate board certification or limitation of professional practice;

(3) Information on usual and customary fees for routine professional services offered which such information shall include notification that fees may be adjusted due to complications or unforeseen circumstances;

(4) Announcement of the opening of, change of, absence from, or return to business;

(5) Announcement of additions to or deletions from professional licensed staff;

(6) The issuance of business or appointment cards.

It is unlawful for any person licensed under this Act to use testimonials or claims of superior quality of care to entice the public. It shall be unlawful to advertise fee comparisons of available services with those of other persons licensed under this Act.

This Act does not authorize the advertising of professional services which the offeror of such services is not licensed to render. Nor shall the advertiser use statements which contain false, fraudulent, deceptive or misleading material or guarantees of success, statements which play upon the vanity or fears of the public, or statements which promote or produce unfair competition.
Amended by P.A. 81-1136, § 1, eff. July 1, 1980.

Trustee District Committees

First District

David B. Littman, Highland Park, Trustee
Counties of Kane, Lake, McHenry

Ethical Relations Committee	Term Expires
David Clark, Aurora, *Chairman*	1987
Gerald Liesen, St. Charles	1988
A. M. Rossetti, McHenry	1986

Peer Review Committee	
David Helberg, Waukegan, *Chairman*	1987
Eugene Pitts, Waukegan	1987
James Pritchard, Geneva	1987
Peter Vinceguerra, Libertyville	1987

Second District

Allan L. Goslin, Streator, *Trustee*
Counties of Bureau, Ford, Grundy, Iroquois, Kankakee, Kendall, LaSalle, Livingston, Marshall, Putnam, Will, Woodford

Ethical Relations Committee	Term Expires
William Erkonen, Streator, *Chairman*	1986
Karl T. Deterding, Pontiac	1986
Julius Kowalski, Princeton	1986
Lawrence D. Lee, Manhattan	1988
Merle Otto, Frankfort	1988
James Ryan, Kankakee	1988

Peer Review Committee	
Ross Hutchison, Gibson City, Chairman	1987
James B. Aplington, LaSalle	1988
Robert Betasso, Ottawa	1988
Silvio Davito, Spring Valley	1988
Bernard J. Doyle, LaSalle	1988
William Ehling, Streator	1986
Guy Pandola, Joliet	1987
A.G. Parkhurst, Kankakee	1986
Alex Spadoni, Joliet	1988
Theodore W. Wagenknecht, Streator	1988

Third District

James H. Andersen, Oak Brook, *Trustee*
Richard Blankshain, Oak Park, *Trustee*
Alfred J. Clementi, Arlington Heights, *Trustee*
Audley F. Connor, Jr., Chicago, *Trustee*
Joan E. Cummings, Hines, *Trustee*
Harold L. Jensen, Flossmoor, *Trustee*
Arthur R. Peterson, Chicago, *Trustee*
Pedro A. Poma, Melrose Park, *Trustee*
Harry A. Springer, Evanston, *Trustee*
Cyril C. Wiggishoff, Chicago, *Trustee*

Fourth District

Lorris M. Bowers, Rock Island, *Trustee*
Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Tazewell, Warren

Ethical Relations Committee	Term Expires
Jerry Ramunis, Victoria, *Chairman*	1988
Earl Clark, Rock Island	1987
Kenneth Ambrose, Monmouth	1988

Peer Review Committee	
James C. Parsons, Geneseo, *Chairman*	1988
Donald Dexter, Macomb	1986
William Dougherty, Moline	1987
Richard Flacco, Galesburg	1988
G. W. Giebelhausen, Peoria	1987
Clarence Ward, Peoria	1987

Fifth District

Robert P. Johnson, Springfield, *Trustee*
Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon

Ethical Relations Committee	Term Expires
Richard H. Suhs, Springfield, *Chairman*	1986
Jack Means, Mason City	1987
A. L. Van Ness, Bloomington	1988

Peer Review Committee	
James Borgerson, Mt. Pulaski, *Chairman*	1986
Paul LaFata, Springfield	1986
Robert B. Perry, Lincoln	1988
Donald Yurdin, Springfield	1988
Albert Cunningham, Normal	1986

Sixth District

George T. Wilkins, Edwardsville, *Trustee*
Counties of Adams, Brown, Calhoun, Cass, Greene, Jersey, Macoupin, Madison, Morgan, Pike, Scott

Ethical Relations Committee	Term Expires
Newton DuPuy, Quincy, *Chairman*	1986
Bernard Baalman, Hardin	1987
Edward K. DuVivier, Alton	1986
C. B. Lara, Pittsfield	1987
Robert Roy, Jacksonville	1987

Peer Review Committee	
Walter Stevenson III, Quincy, *Chairman*	1986
Robert England, Carlinville	1987
Robert F. Hamilton, Alton	1987
Robert C. Murphy, Quincy	1988
Edward Ragsdale, Alton	1986
James Sutherland, Quincy	1986

Seventh District

Alfred J. Kiessel, Decatur, *Trustee*
Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby

Ethical Relations Committee	Term Expires
Delbert H. Hahn, Jr., Decatur, *Chairman*	1988
Muhammad T. Salaymeh, Taylorville	1988
E. F. Stephens, III, Centralia	1988

Peer Review Committee	
M. K. Kaufman, Greenville, *Chairman*	1986
H. Gale Zacheis, Decatur	1986
Clarence G. Glenn, Decatur	1988
D. H. Rames, Vandalia	1988

Eighth District

Eugene P. Johnson, Casey, *Trustee*
Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion

Ethical Relations Committee	Term Expires
Mack W. Hollowell, Charleston, *Chairman*	1986
Charles L. Lansford, Urbana	1988
James H. Pass, Olney	1987
Stanley R. Huffman, Charleston	1986

Peer Review Committee	
George T. Mitchell, Marshall, *Chairman*	1987
Edward S. Warren, Danville	1986
R. C. Adams, Champaign	1988

Ninth District

Warren D. Tuttle, Harrisburg, *Trustee*
Counties of Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson

Ethical Relations Committee	Term Expires
Richard L. Morgan, Marion, *Chairman*	1988
Eli Borkon, Carbondale	1986
Robert Rader, Anna	1986

Peer Review Committee	
Philip D. Boren, Carmi, *Chairman*	1988
Larry Jones, Harrisburg	1987
Roger Klam, Carbondale	1987
Harry L. Lewis, Benton	1988
Eugene B. Loftin, Fairfield	1988
Charles K. Wells, Mt. Vernon	1988

Tenth District

Thomas P. Meirink, Belleville, *Trustee*
Counties of Monroe, Perry, Randolph, St. Clair, Washington

Ethical Relations Committee	Term Expires
H. P. Dexheimer, Belleville, *Chairman*	1988
Charles Frazer, E. St. Louis	1988
Edilberto Maglasang, Columbia	1988
Wm. A. Simmons, Belleville	1988

Peer Review Committee	
Theodore L. Bryan, Belleville, *Chairman*	1987
Henry Hurd, Belleville	1988
R. W. Jost, Waterloo	1987
R. E. Schettler, Red Bud	1986
Ronald G. Welch, Belleville	1987

Eleventh District

Raymond A. Dieter, Jr., Glen Ellyn, *Trustee*
County of DuPage

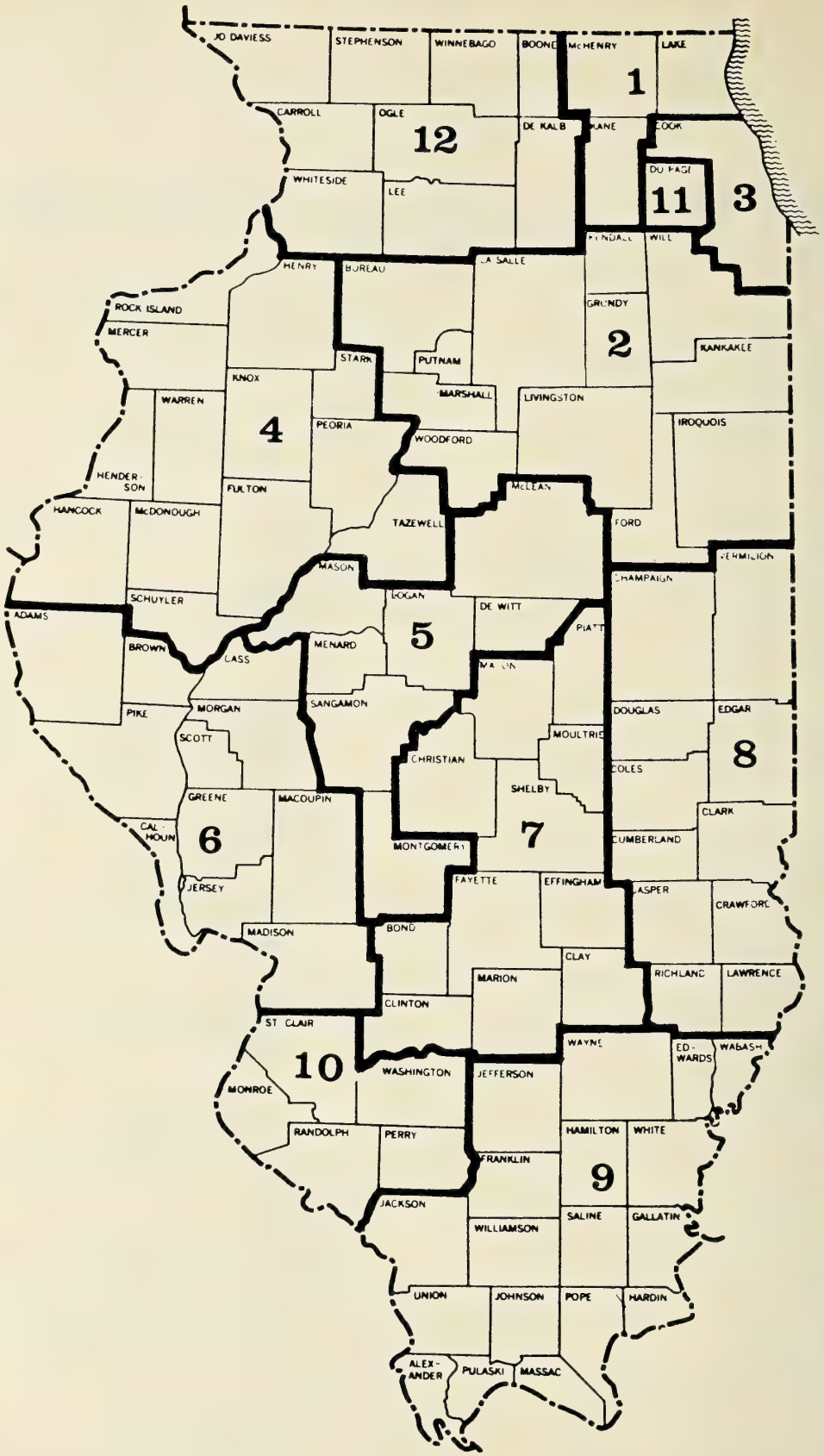
Twelfth District

Raymond E. Hoffmann, Rockford, *Trustee*
Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago

Ethical Relations Committee	Term Expires
John W. Ovitz, Jr., Sycamore, *Chairman*	1986
William Isham, Freeport	1986
John H. Steinkamp, Belvidere	1987
Daniel Swift, Rockford	1987
Richard S. Webb, Jr., Rockford	1986

Peer Review Committee	
John W. Ovitz, Jr., Sycamore, *Chairman*	1986
William Isham, Freeport	1986
John H. Steinkamp, Belvidere	1987
Daniel Swift, Rockford	1987
Richard S. Webb, Jr., Rockford	1986

ISMS TRUSTEE DISTRICTS



1985 Officers of County Medical Societies

County	*Members*	*President*	*Secretary*
Adams	Members: 92-Dist. 6 Maxine Boyer, Ex. Sec., 2039 Sunnybrook, P.O. Box 767, Quincy 62306	Philip C. Wilson 1101 Main, Quincy 62301	Richard L. Newman 1225 Broadway, Quincy 62301
Alexander-Pulaski	Members: 5-Dist. 9	Crisostomo Lozada 529 Cross St., Cairo 62914	Gemo Wong P.O. Box 233, Cairo 62914
Bond	Members: 8-Dist. 7	Boyd A. McCracken Health Care Drive, Rural Rt. 3, Box 40 Greenville 62246	Charles Daisy 308 W. College Greenville 62246
Boone	Members: 24-Dist. 12	Anthony Molinari 119 S. State St. Belvidere 61008	John Steinkamp 824 Van Buren, Belvidere 61008
Bureau	Members: 38-Dist. 2	Paul V. Paul 1302 N. Greenwood, Spring Valley 61362	Rakesh K. Garg 600 E. First, Spring Valley 61362
Carroll	Members: 8-Dist. 12	Cecil G. Piper 203 W. Market, Mt. Carroll 61053	Basilios G. Lambos 202 Main St., Savanna 61074
Champaign	Members: 315-Dist. 8 Larry Booth, Ex. Sec., 1408 W. University, Urbana 61801	Milton Carlson 104 W. Clark, Champaign 61820	Robert E. Welke Carle Clinic, 602 W. University, Urbana 61801
Christian	Members: 23-Dist. 7	Virgilio Dycoco 217 S. Locust, Pana 62557	I. Del Valle 311 S. Main, Taylorville 62568
Clark	Members: 4-Dist. 8	George T. Mitchell Cork Medical Center, Marshall 62441	Steven Macke Cork Medical Center, Marshall 62441
Clay	Members: 6-Dist. 7	Alva P. Naney, Jr. 433 E. 7th St., Flora 62839	Eugene Foss 115 W. 2nd St., Flora 62839
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DeWitt	Members: 9-Dist. 5	John W. Veirs 219 E. Main, Clinton 61727	C. N. Radhakrishna 210 E. Main, Clinton 61727
Douglas	Members: 9-Dist. 8	Grant A. Jones 318 S. Ash, Arthur 61911	Robert Arrol 126 S. Locust, Arcola 61910
DuPage	Members: 774-Dist. 11 Lillian Widmer, Ex. Admin., 800 Roosevelt Road, Building B-Suite 300, Glen Ellyn 60137	Erlo Roth 8999 S. County Line Rd., Hinsdale 60521	James P. Campbell 322 N. Blanchard St., Wheaton 60187
Edgar	Members: 13-Dist. 8	Duane Haskell 502 Shaw, Paris 61944	J. M. Ingalls Medical Center Clinic, Paris 61944
Effingham	Members: 25-Dist. 7	Ruben Boyajian P.O. Box 1139, Effingham 62401	Herbert F. Webb P.O. Box 1268, Effingham 62401
Fayette	Members: 11-Dist. 7	Joshua Weiner 1007 N. Eighth St., Vandalia 62471	Vasudev Kachgal 802 N. Eighth, Vandalia 62471
Ford	Members: 15-Dist. 2	Robert Arthur P.O. Box 527, Gibson City 60936	David J. Hagan 214 N. Sangamon, Gibson City 60936
Franklin	Members: 22-Dist. 9	Harry L. Lewis Benton Medical Center, Benton 62812	Bob G. Thompson 309 W. St. Louis St., W. Frankfort 62896
Fulton	Members: 40-Dist. 4	John H. Day R.R. 4, Canton 61520	Hassan I. Alsheik P.O. Box 498, Canton 61520
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Greene	Members: 6-Dist. 6	Jude A. Caselton 727 South 9th, Carrollton 62016	James C. Reid Fillonger Memorial Clinic 712 S. College, Greenfield 62044
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Henderson	Members: 1-Dist. 4	Silvino Lindo, Jr. Box 248, Biggsville 61418	Silvino Lindo, Jr. Box 248, Biggsville 61418
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Iroquois	Members: 21-Dist. 2	A.T. DeVas Gunawardhane 355 E. 6th Ave. Clifton 60927	Dominic Imburgia 618 S. 5th St., Watseka 60970

County	*Members*	*President*	*Secretary*
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Jo-Daviess	Members: 8-Dist. 12	Wilbur E. Johnson 219 Summit St., Galena 61036	Wilbur E. Johnson 219 Summit St., Galena 61036
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Alfred J. Clementi, Arlington Heights
Allan L. Goslin, Streator*
Robert C. Hamilton, Chicago
Robert P. Johnson, Springfield
Morgan M. Meyer, Lombard
Joseph H. Skom, Chicago
Arthur Traugott, Urbana
Cyril C. Wiggishoff, Chicago

To Serve from Jan. 1, 1985 to Dec. 31 1986 (Elected April 8, 1984)

Audley F. Connor, Jr., Chicago
David S. Fox, Chicago
Henrietta Herbolsheimer, Chicago
Lawrence L. Hirsch, Northbrook
Michael L. Nieder, Chicago
Joseph R. O'Donnell, Glen Ellyn
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P. John Seward, Rockford
Fred Z. White, Chillicothe
George T. Wilkins, Jr., Edwardsville

To serve from Jan. 1, 1986 to Dec. 31, 1987 (Elected April 27, 1985)

Alfred J. Clementi, Arlington Heights
Jere E. Freidheim, Chicago
Allan L. Goslin, Streator
Robert C. Hamilton, Chicago
Harold Jensen, Flossmoor
Robert P. Johnson, Springfield
Morgan M. Meyer, Lombard
Harry A. Springer, Evanston
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Alternates

To serve from Jan. 1, 1984 to Dec. 31, 1985 (Elected April 24, 1983)

Randall T. Bellows, Chicago
Albino Bismonte, Waukegan****
Joan E. Cummings, Chicago**
Ulrich Danckers, River Forest****
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Harold Jensen, Flossmoor
A. Beaumont Johnson, Elgin
Carlos B. Lara, Pittsfield
Pedro A. Poma, Melrose Park
Warren D. Tuttle, Harrisburg
Ronald Welch, Belleville

To Serve from Jan. 1, 1985 to Dec. 31, 1986 (Elected April 8, 1984)

James H. Andersen, Oak Brook
James DeBord, Peoria
Manuel Guerrero, Rock Island**
Alfred J. Kiessel, Decatur
William J. Marshall, Chicago***
Joseph B. Perez, Rockford
Clifton L. Reeder, Wilmette
Harry A. Springer, Evanston
Robert M. Vanecko, Chicago
Nancy Zamora, Rockford

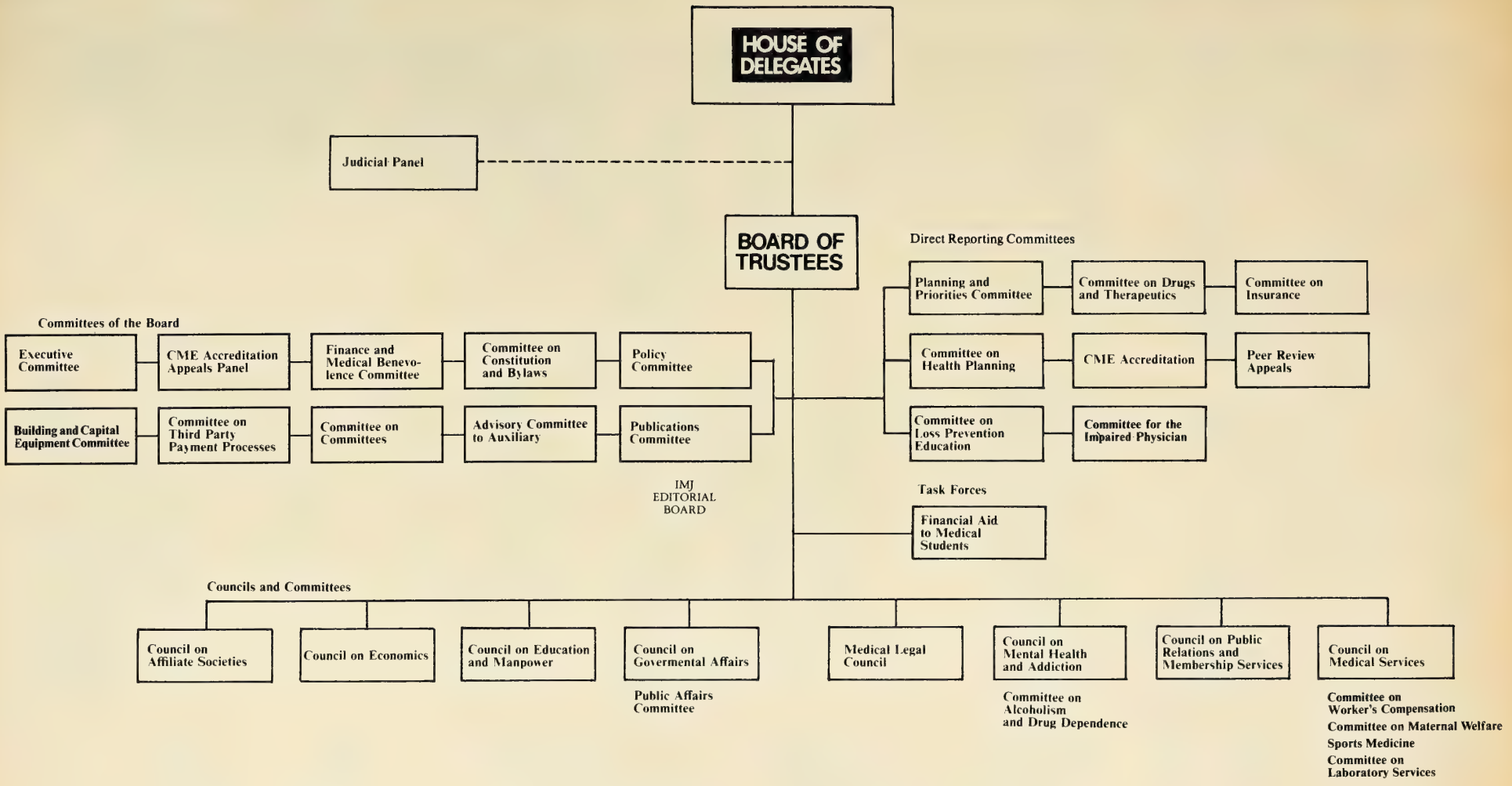
To serve from Jan. 1, 1986 to Dec. 31, 1987 (Elected April 27, 1985)

Randall T. Bellows, Chicago
Albino Bismonte, Waukegan
Joan E. Cummings, Chicago
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Carlos B. Lara, Pittsfield
Joseph H. Skom, Chicago
Warren D. Tuttle, Harrisburg
Ronald Welch, Belleville

**Elected to 19th position, April 27, 1985*
***Elected to 18th position, April 27, 1985*
****Elected April 27, 1985 to completed unexpired term Jan. 1 to Dec. 31, 1986*
*****Elected April 27, 1985 to complete unexpired term until Dec. 31, 1985.*

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- Illinois Foundation for Medical Care
- Illinois Council on Continuing Medical Education
- Illinois State Medical Benevolent Fund, Inc.
- Illinois State Medical Insurance Services, Inc.
- Illinois State Medical Inter-Insurance Exchange
- ISMS Educational and Scientific Foundation
- ISMS Hospital Medical Staff Section
- Medical Student Section
- Resident Physician Section

Organizations with formal ISMS Representation

- Swanberg Foundation
- Ill. Society, American Association of Medical Assistants
- Ill. Interagency Council on Smoking and Disease
- M.D. Committee on Optometry
- INA/ISMS Joint Practice Comm.
- Ill. Medical Records Assn.
- Illinois Cancer Council
- IMPAC
- Citizen's Committee on an Illinois Program to Control High Blood Pressure
- U. S. Pharmacopaeia
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Councils of the Illinois State Medical Society

Councils of the Illinois State Medical Society are appointed by the Chairman of the Board of Trustees subject to approval of the Board of Trustees. The councils are composed of such members as are necessary to accomplish the purposes of the council. Some committees are composed of members of the Board of Trustees and are designated Board committees. Some free standing committees may report directly to the Board and may not be assigned to a council. Task forces are established to address a particular problem or concern which crosses areas of responsibility of the several councils. The task forces report directly to the Board, as do representatives to various other agencies. The President, Speaker of the House, and Chairman of the Board are, by virtue of their office, *ex-officio* members of all groups.

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Illinois Neurological Society
Illinois State Urological Society
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Robert C. Wanless, Belleville

Consultants:
Raymond A. Dieter, Jr., Glen Ellyn
Lawrence L. Hirsch, Northbrook
Harold L. Jensen, Flossmoor
Robert Reardon, Bloomington
Arthur R. Traugott, Urbana

Resident Representative
Mike Silver, Oak Park

Student
Thomas Zusag, Chicago

Auxiliary Representative
Nancy A. Hoffmann, Rockford

Responsibilities and Purposes:

The Council on Economics considers issues that are of direct and immediate economic concern to the practice of medicine in Illinois. The council is interested in effective practice management and the economic impact of governmental health care activities and policies, private health care initiatives, alternative health care delivery systems and the activities of the various utilization review agencies (i.e., PRO, Foundations for Medical Care and private preadmission review initiatives). The council analyzes the impact of these programs, both existing and proposed, and reports its recommendations to the Board of Trustees.

COUNCIL ON EDUCATION AND MANPOWER

Eugene B. Loftin, Fairfield, *Chairman*
Francois Alouf, Chicago
Andres D. Botuyan, Chicago
John J. Coon, Peoria
Mary Jensen, Chicago
Ronald Johnson, Pittsfield
Natalie Stephens, Chicago

Consultants
Jere E. Freidheim, Chicago
Jack Gibbs, Canton
Lawrence L. Hirsch, Northbrook
Robert P. Johnson, Springfield
Arthur R. Traugott, Urbana
George T. Wilkins, Edwardsville

Resident Representative
John Diveris, Chicago

Student Representative
Marcus L. Wever, Springfield

IMGMA Representative
Steven R. Perrigo, Springfield

Responsibilities and Purposes:

The Council on Education and Manpower shall study and evaluate all phases of medical education, including the development of programs by and for ISMS, and review programs for allied health personnel. It shall carry to the deans of medical schools recommendations from the viewpoint of the practicing physician. It shall evaluate available postgraduate programs, advise the Illinois Dept. of R&E, and review hospital oriented education programs. Liaison shall be maintained with medical students and physicians-in-training and with loan programs for medical students. Activities regarding physician distribution and retention shall also be within the scope of the Council, as well as medical licensure as it relates to education.

GOVERNMENTAL AFFAIRS COUNCIL

Joseph Purpura, Lake Forest
Chairman
Gerald M. Casey, Oak Lawn
Edward Ference, Springfield
David S. Fox, Chicago
Terry Mason, Chicago
George T. Mitchell, Marshall
Tassos Nassos, Northbrook
John Ovitz, Sycamore
Edward Ragsdale, Alton
Jerry Ramunis, Galesburg
Albert W. Ray, Jr., Joliet
P. John Seward, Loves Park
Herbert Sohn, Chicago
Stephen Stone, Springfield
Earl Suckow, Mt. Prospect
William Tansey, Downers Grove
Hugo Velarde, Highland Park

Consultants
William J. Marshall, Olympia Fields
Thomas P. Meirink, Belleville
Ronald Welch, Belleville
George T. Wilkins, Jr., Edwardsville

Auxiliary Representative
Mrs. Pam Taylor, Danville

Student Representative
Mark Dobbertien, Chicago

Resident Representative
Bruce Doblin, Chicago

Illinois Medical Group Management Association Representative
Dennis Mock, Chicago

Responsibilities and Purposes:

1. Keep the Society and its members aware of all state and federal legislation and laws affecting the health of citizens of Illinois and the practice of medicine in Illinois.
2. Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois.
3. Co-operate with the AMA in similar programs.
4. Develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

Committees:

Public Affairs

PUBLIC AFFAIRS COMMITTEE

Albert W. Ray, Jr., Joliet
Chairman
Earl E. Fredrick, Chicago
Don E. Hinderliter, Rochelle
Harold Lasky, Chicago
Paul F. Mahon, Springfield
Richard Schenk, Urbana
Patrick Staunton, Park Ridge
Jerome Weiskopf, Rockford

Auxiliary Representative
Mrs. Suzanne Meirink, Belleville

Responsibilities and Purposes:

The Public Affairs Committee is responsible for educating physicians about the political process and encouraging political involvement. The Committee also provides educational material on issues of interest to physicians and promotes physician involvement in public affairs activity.

MEDICAL LEGAL COUNCIL

Donal D. O'Sullivan, Oak Park, *Chairman*
Susan Balter, River Forest
Geoffrey Bland, Springfield
Robert Eilers, Burr Ridge
Gerardo Grieco, Chicago
Kenneth D. Hansen, Carbondale
Charles A. Janda, Oak Brook
David B. Lewis, Springfield
Robert Libman, Chicago
M. Leroy Sprang, Evanston
Michael G. Victor, Barrington

Consultants
James Andersen, Oak Brook
Ulrich F. Danckers, Melrose Park
Raymond Dieter, Jr., Glen Ellyn
Warren D. Tuttle, Harrisburg

Resident Representative
J. Michael Tuchek, Oak Park

Auxiliary Representative
Vivian Reardon, Bloomington

Responsibilities and Purposes:

The Council cooperates with all organizations interested in medico-legal problems and educates members of the profession in such affairs. In addition, the Council is concerned with standards of practice, licensure and quackery.

This Council maintains liaison with the Illinois State Bar Association and cooperates with the judiciary in both federal and state courts within the state of Illinois. It shall, when requested by the court, activate the Impartial Medical Evaluator Panel. The stated objective of the panel is to provide consultations, judgment and opinions in situations in which there is unusual controversy or wide divergence of medical opinion.

COUNCIL ON MEDICAL SERVICES

Joseph D. Winterhalter, Jacksonville, *Chairman*
Donald Graham, Springfield
Henrietta Herbolsheimer, Chicago
James L. McGee, Decatur
Donald F. Pochyly, River Forest
Forrest H. Riordan, III, Rockford
Marvin A. Rosner, Chicago
Nunilo Rubio, Chicago
Dennis Stanczyk, Belleville
Alan Stein, Alton

CONSULTANTS:
Joan Cummings, Hines
Raymond E. Hoffmann, Rockford
David B. Littman, Highland Park
Fred Z. White, Chillicothe

STUDENT REPRESENTATIVE
Barry Ticho, Chicago

AUXILIARY REPRESENTATIVE
Carolyn Chapman, Belleville

IDPH REPRESENTATIVE
Bernard Turnock, Springfield

Responsibilities and Purposes:

The Council considers a broad range of issues and programs related to medical facilities, professional health education, public health, laboratory services and services for the disadvantaged. Specific interest areas include nutrition, hospital-medical staff relations, emergency medical services, maternal and child welfare, workers' compensation, sports medicine, and penal health care services.

Committees:

Laboratory Services
Maternal Welfare
Sports Medicine
Workers' Compensation

COMMITTEE ON LABORATORY SERVICES

Antoinette Thomas, Carbondale *Chairman*
David Duffell, Arlington Heights
Thomas Harwood, Chicago
Gerald G. Hoffman, Lake Forest
C. M. Modi, Chicago
Vincent T. Mosquera, Clarendon Hills
Erlo Roth, Hinsdale
Harold Rothenberg, Chicago
Marshall H. Short, Chicago

CONSULTANT:
Alfred J. Kiessel, Decatur

Responsibilities and Purposes:

The Committee considers issues and programs pertaining to medical laboratories, blood banking, and related areas affecting the practice of medicine in Illinois; handles matters brought to its attention by the Council on Medical Services; reviews matters related to standards of practice and provides guidance on improving patient care provided via medical laboratories, blood banks, and related entities; works with state agencies on matters relating to medical laboratories, blood banks, and related areas; and oversees ISMS direction to support the provision of blood transfusion services that meet the needs of the patients throughout Illinois, via coordinating activities and discussions with blood banks.

COMMITTEE ON MATERNAL WELFARE

DISTRICT MEMBERS AND ALTERNATES
(alternates in italics)

1. Joseph Burke, Waukegan
William R. Larsen, Woodstock
2. Carl P. Mattioda, Streator
Leo Wrona, Joliet
3. Marvin A. Rosner, Chicago, *Chairman*
Ulisse Cucco, Mt. Prospect
4. Raouf E. Reinertsen, Galesburg
Robert Westefer, Peoria
5. William H. Schultz, Springfield
Robert C. Kaufman, Springfield
6. Richard D. Yoder, Alton
7. Herbert W. Thompson, Decatur
William Van Bergan, Effingham
8. Lewis Trupin, Champaign
Juan F. Rojas, Danville
9. Cynthia A. Fraed, Harrisburg
Allan G. Bennett, Carbondale
10. Stephen V. Mueller, Belleville
Rosel Calong, Belleville
11. A. William Schafer, Hinsdale
Thomas R. Eckman, Downers Grove
12. John E. Tillis, Rockford
John T. Leonard, Rockford

CONSULTANTS:
Robert R. Hartman, Jacksonville
John Louis, Lake Forest
Ed Ryan, Palos Park
Richard Gelfand, Evanston
Augusta Webster, Chicago
Diane Mertens, Springfield
Bernard Turnock, Springfield

Responsibilities and Purposes:

The primary responsibility of this committee is to review cases of maternal mortality in Illinois. This function is performed under a contract with the state health department. The Committee also deals with issues involving maternal health services and perinatal care.

SPORTS MEDICINE COMMITTEE

Ed Grogg, Urbana, *Chairman*
David Anzaldua, Peoria
Craig Dean, Libertyville
James L. Green, Jacksonville
James A. Hill, Chicago
Robert M. Jarrett, Rockford
H. Bates Noble, Chicago
Cameron Olson, Springfield
William T. Sheehy, Elgin
Howard J. Sweeney, Evanston
Eugene Tanski, Chicago
Edward Winslow, Wilmette

CONSULTANTS:
Audley F. Connor, Jr., Chicago
Robert C. Hamilton, Chicago

AUXILIARY REPRESENTATIVE
Mrs. Harold Keegan, Kankakee

Responsibilities and Purposes:

The committee conducts programs aimed at improving the recognition and treatment of athletic-related injury and disease; provides educational material to junior and senior high school coaches and trainers; and works with other groups and organizations involved in sports medicine activities.

COMMITTEE ON WORKERS' COMPENSATION

Forrest H. Riordan, III, Rockford, *Chairman*
E. Richard Blonsky, Chicago
Richard Geline, Skokie
Henry Gross, Peoria
Gerald A. Jabaay, Carol Stream
James LaFata, Springfield
Alvin Palow, Kankakee
Alberto E. Rodriguez, Oak Park
James R. Ryan, DesPlaines

Responsibilities and Purposes:

The committee reviews how physicians are involved and affected by the workers' compensation system in Illinois.

COUNCIL ON MENTAL HEALTH AND ADDICTION

LeRoy P. Levitt, Chicago, *Chairman*
Fern E. Asma, Chicago
Richard Banta, Rockford
Helen R. Beiser, Chicago
Brad Colen, Peoria
Earl Loschen, Springfield
Silvana Menendez, Belleville
Thomas Minogue, Urbana
Kishore Thampy, Chicago
Ruth Wharton, River Forest

Consultants:
Allan L. Goslin, Streator
Eugene Johnson, Casey

Auxiliary Representative
Mrs. Alex Spadoni, Hinsdale

Student Representative
Edie Zusman, Chicago

Resident Representative
Frank Pieri, Chicago

Ill. Dept. of Mental Health and Developmental Disabilities Rep.
Paul M. Schyve

Responsibilities and Purposes:

This council serves as a source of information on mental health matters for ISMS, evaluates information and makes recommendations to the Board of Trustees on positions the Society should take on issues in this area and cooperates with institutions, voluntary health agencies, state agencies and professional associations in disseminating information on mental health, alcoholism and drug abuse. It is also concerned with reviewing legislation and regulations related to the fields of mental health, alcoholism, drug abuse and controlled substances.

Committee:

Alcoholism and Drug Dependence

COMMITTEE ON ALCOHOLISM AND DRUG DEPENDENCE

Ruth Wharton, River Forest, *Chairman*
Sam Gaines, Springfield
Andrew Griffin, Chicago
James Mulry, Springfield
David Spencer, Springfield
Peter Talso, Chicago

Consultants:
Roalda J. Alderman, Dept. of Alcoholism and Substance Abuse
Daniel Behnke, Dept. of Alcoholism and Substance Abuse

Auxiliary Representative
Mrs. Cheryl White, Springfield

IMGMA Representative
Barbara Birnbaum, Chicago

Responsibilities and Purposes:

The committee works closely with public and private agencies on projects aimed at eliminating the misuse of alcohol and drugs.

COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Albino T. Bismonte, Gurnee, *Chairman*
Jane Jackman, Springfield
Ronald L. Kirschner, Glenview
Richard A. Perritt, Chicago
Clifton L. Reeder, Wilmette
David A. Rothstein, Chicago
Hilliard E. Slavick, Chicago
William B. Spriegel, Evanston

Consultant Trustees:
Eugene P. Johnson, Casey
Pedro A. Poma, Melrose Park
Harry A. Springer, Evanston

Consultant County Executives:
John Hanni, Peoria
Fred Schwartz, Chicago
Lillian Widmer, Glen Ellyn
Madge Williams, Bloomington

Resident Representative
Mark Ridlen, Springfield

Student Representative
Jennifer Souders, Chicago

Auxiliary Representative
Mrs. Lynn Kassel, Joliet

IMGMA Representative
John Robertson

Responsibilities and Purposes:

The Council on Public Relations and Membership Services shall plan and execute programs designed to enhance relationships between the media, public and members of the medical profession; and to retain and recruit members in the Society.

Committees of the Board of Trustees

ADVISORY COMMITTEE TO ISMS AUXILIARY

Robert C. Hamilton, Chicago, *Chairman*
Alfred J. Clementi, Arlington Heights
Morgan M. Meyer, Lombard

Responsibilities and Purposes:

The Committee shall consist of the immediate past president as chairman, the president, and the chairman of the Board. The Committee shall provide advice and assistance to the president of the ISMS Auxiliary in her program for the year, and shall assist her in interpreting the activities of the state medical society to the auxiliary members. It shall also monitor the services provided by ISMS to the Auxiliary.

BUILDING AND CAPITAL EQUIPMENT COMMITTEE

Ronald G. Welch, Belleville, *Chairman*
Alfred J. Clementi, Arlington Heights
Jere E. Freidheim, Chicago
Morgan M. Meyer, Lombard
Warren D. Tuttle, Harrisburg
Cyril C. Wiggishoff, Chicago

Responsibilities and Purposes:

The Committee shall review and monitor activities pertaining to the building and capital equipment.

COMMITTEE ON COMMITTEES

Harold L. Jensen, Flossmoor, *Chairman*
Ulrich F. Danckers, River Forest
Allan L. Goslin, Streator
Raymond E. Hoffmann, Rockford

Responsibilities and Purposes:

The Committee on Committees shall consist of members of the Board appointed by the chairman. It shall serve to review the purposes, activities and structure of any councils or committees at the request of the Board.

The Committee shall recommend such changes in existing councils or committees as required to maintain the efficient operation of the affairs of the Society.

The activities and reports of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

COMMITTEE ON CONSTITUTION AND BYLAWS

James H. Andersen, Oak Brook, *Chairman*
Lawrence L. Hirsch, Northbrook
Thomas P. Meirink, Belleville
Robert M. Reardon, Bloomington
George T. Wilkins, Jr., Edwardsville

Responsibilities and Purposes:

The Committee on Constitution and Bylaws shall:

1) Receive from individual members, county societies, committees, the Board of Trustees and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws;

2) Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws; and

3) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

CME ACCREDITATION APPEALS PANEL

Lorris M. Bowers, Peoria
William J. Marshall, Flossmoor
Pedro A. Poma, Melrose Park
Harry A. Springer, Evanston
Warren D. Tuttle, Harrisburg
Fred Z. White, Chillicothe
George T. Wilkins, Jr., Edwardsville

Responsibilities and Purposes:

In the event the Committee on CME Accreditation makes a non-accreditation decision to an Illinois CME sponsor, the sponsor may make a formal appeal to this hearing committee, which, in turn, will make a formal recommendation to the ISMS Board of Trustees on the sponsor's application.

EXECUTIVE COMMITTEE

Alfred J. Clementi, Arlington Heights, *Chairman*
Jere E. Freidheim, Chicago
Robert C. Hamilton, Chicago
Morgan M. Meyer, Lombard
Arthur R. Traugott, Urbana
Warren D. Tuttle, Harrisburg
Ronald G. Welch, Belleville
Cyril C. Wiggishoff, Chicago

Ex Officio (without vote)
Lawrence L. Hirsch, Northbrook
Fred Z. White, Chillicothe

Responsibilities and Purposes:

The Executive Committee shall consist of the president, the president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer and the trustee-at-large. The immediate past chairman of the Board shall be a member, provided he is still a Trustee. If the immediate past chairman is no longer a Trustee, the chairman of the Policy Committee shall serve on the Executive Committee.

The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, the chairman of the Board of Governors of the Illinois State Medical Inter-Insurance Exchange and the speaker of the House of Delegates, or the vice speaker in his absence, shall serve as ex-officio members of the Executive Committee without vote.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

(Bylaws, Chapter IX, Part 4, Section 2, Paragraph A.)

FINANCE AND MEDICAL BENEVOLENCE COMMITTEE

Cyril C. Wiggishoff, Chicago, *Chairman*
Eugene P. Johnson, Casey
Harry A. Springer, Evanston
Ronald G. Welch, Belleville

Auxiliary Representatives
Mrs. Louis Tarsinos

Responsibilities and Purposes:

The Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop a budget for the fiscal year for approval of the Board through the Executive Committee. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

The Finance Committee shall also be responsible for the Society's Medical Benevolence Program and shall:

1. Examine applications for financial assistance and determine eligibility.
2. Keep the names of the beneficiaries confidential and known only to the committee.
3. Determine the allotment for each recipient.
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

POLICY COMMITTEE

Alfred J. Kiessel, Decatur, *Chairman*
Joan E. Cummings, Hines
William J. Marshall, Olympia Fields

Responsibilities and Purposes:

The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall annually review all policy statements adopted five or more years previously and incorporate suggestions for revisions and deletions into resolutions for approval by the Board of Trustees and introduction in the House of Delegates. It shall also make recommendations for future policy by Board resolution to the House.

PUBLICATIONS COMMITTEE

Pedro A. Poma, Melrose Park, *Chairman*
Joan E. Cummings, Hines
Raymond A. Dieter, Jr., Glen Ellyn
David B. Littman, Highland Park
Arthur R. Peterson, Chicago

Responsibilities and Purposes:

The Publications Committee shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal* and other Society publications.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal*. It shall supervise the editorial board in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates and standards, shall review all new accounts prior to acceptance and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the *Journal*.

The committee may establish such editorial consultation groups as necessary to assist in development of clinical articles and shall authorize all regular and special features.

IMJ Editorial Board

J. William Roddick, Jr., Springfield, *Chairman*
Eli L. Borken, Carbondale
Joseph R. Christian, Chicago
Ediz Z. Ezdinli, Kenilworth
Larry C. Gunn, Hinsdale
Eugene J. Rogers, Chicago
Constantine S. Soter, Arlington Heights
David E. Trachtenbarg, Peoria
Donald D. VanFossan, Springfield
Edward A. Wolpert, Chicago

THIRD PARTY PAYMENT PROCESSES COMMITTEE

Arthur R. Traugott, Urbana, *Chairman*
James H. Andersen, Oak Brook
Audley F. Connor, Jr., Chicago
Allan L. Goslin, Streator
Harold L. Jensen, Flossmoor
Robert P. Johnson, Springfield
Arthur R. Peterson, Chicago

CONSULTANT:
Alfred J. Kiessel, Decatur

ILL. MEDICAL GROUP MNGMT. ASSOC. REP.
Nancy Koch, Chicago

Responsibilities and Purposes:

The Committee on Third Party Payment Processes is a committee of the Board of Trustees. Its primary responsibility is to interact with the appropriate governmental and private third party reimbursement agencies on matters that require a negotiating role at the Board level. It monitors the activities of the Illinois Department of Public Aid, the Medicare program in Illinois, the CHAMPUS program in Illinois, Blue Cross/Blue Shield, other private insurers and other appropriate agencies whose problems have a significant impact on physician reimbursement. This committee negotiates with those entities under the direction of the Board of Trustees to effect appropriate changes in their policies, procedures and programs.

Direct Reporting Committees

All Board Committees previously noted consist of members of the Board of Trustees. As such they function within the activities of the Board.

Direct Reporting Committees are groups deemed necessary by the Board of Trustees and are created by the Board to meet specific challenges. These committees may function with, and under, a council, or may report directly to the Board of Trustees.

While other select committees may be formed from time to time, at the time of publication the following groups had been established.

COMMITTEE ON CME ACCREDITATION

Terry F. Hatch, Urbana, *Chairman*
Walter F. Kondratowicz, Chicago
James Russell, Naperville
Anthony Sapienza, Chicago
Birendra K. Sinha, Elk Grove Village
Simon Zivin, Lincolnwood

CONSULTANT:
David B. Littman, Highland Park
Pedro A. Poma, Melrose Park

Responsibilities and Purposes:

Adopt necessary procedural rules and prescribe forms to be used in the conduct of CME accreditation, within prescribed policies. Review sponsor applications and survey team reports for intrastate CME sponsors, and make decisions on grant of initial accreditation and continuation of accredited status.

Illinois CME Sponsors Accredited for Continuing Medical Education As of September 30, 1985

Alexian Brothers Medical Center—Elk Grove Village
American Heart Assn. (Ill. Affiliate)
Augustana Hospital—Chicago
Belleville Hospital Association for CME (Memorial Hospital, St. Elizabeth Hospital)
Carle Foundation Hospital—Urbana
Central Community Hospital—Chicago
Central DuPage Hospital—Winfield
Chicago Center Hospital
Chicago College of Osteopathic Medicine
Chicago Medical Society
Christ Hospital—Oak Lawn
Columbus-Cuneo-Cabrini Medical Center—Chicago
Condell Memorial Hospital—Libertyville
Copley-Mercy CME Consortium—Aurora
DuPage County Medical Society
Edgewater Hospital—Chicago
Elgin Mental Health Center
FAB^3-CME—(Forkosh Memorial, Belmont Community, Bethesda, Bethany Methodist, Thorek Medical Center)—Chicago
Forest Hospital—DesPlaines
Franciscan Medical Center—Rock Island
Glendale Heights Community Hospital
Good Samaritan Hospital—Downers Grove
Good Samaritan Hospital—Mt. Vernon
Gottlieb Memorial Hospital—Melrose Park
Grant Hospital of Chicago
Henry Horner Childrens' Center—Chicago
Highland Park Hospital
Hinsdale Sanitarium & Hospital
Holy Cross Hospital—Chicago
Humana Hospital—Hoffman Estates
Hyde Park Community Hospital—Chicago
Illinois Council on Continuing Medical Education
Illinois Masonic Medical Center—Chicago
Ingalls Memorial Hospital—Harvey
Institute for Psychoanalysis—Chicago
Jackson Park Hospital—Chicago
Kishwaukee Community Health Center—DeKalb
Lake Forest Hospital
Loretto Hospital—Chicago
Louis A. Weiss Memorial Hospital—Chicago
Loyola University Stritch School of Medicine—Maywood
Lutheran General Hospital—Park Ridge
Lutheran Hospital—Moline
MacNeal Memorial Hospital—Berwyn
Martha Washington Hospital—Chicago
Mary Thompson Hospital—Chicago
Memorial Hospital of DuPage County—Elmhurst

Mercy Hospital & Medical Center—Chicago
The Methodist Medical Center of Illinois—Peoria
Mount Sinai Hospital Medical Center of Chicago
Northwestern University Medical School—Chicago
North Shore Mental Health Association/Irene Josselyn Clinic—Northfield
Northwest Hospital—Chicago
Northwest Community Hospital—Arlington Heights
Norwegian-American Hospital—Chicago
Oak Forest Hospital
Oak Park Hospital
Prairie Cardiovascular Center—Springfield
Provident Hospital—Chicago
Ravenswood Hospital Medical Center—Chicago
Resurrection Hospital—Chicago
Riveredge Hospital—Forest Park
Riverside Hospital—Kankakee
Rockford Memorial Hospital
Rush Medical College—Chicago
St. Anne's Hospital—Chicago
St. Anthony Hospital—Chicago
St. Anthony Hospital—Rockford
St. Elizabeth's Hospital—Chicago
St. Elizabeth Hospital—Danville
St. Francis Hospital—Evanston
St. Francis Hospital-Medical Center—Peoria
St. Joseph Hospital—Chicago
St. Joseph Hospital—Elgin
St. Mary's Hospital—Kankakee
St. Mary's Hospital—Streator
St. Mary of Nazareth Hospital—Chicago
St. Therese Hospital—Waukegan
Sarah Bush Lincoln Health Center—Mattoon
Sherman Hospital—Elgin
Shriner's Hospital for Crippled Children—Chicago
Silver Cross Hospital—Joliet
Skokie Valley Community Hospital—Skokie
South Chicago Community Hospital
Southern Illinois University School of Medicine—Springfield
Springfield Clinic
Swedish American Hospital—Rockford
Swedish Covenant Hospital—Chicago
University of Chicago Pritzker School of Medicine
University of Health Sciences/The Chicago Medical School
University of Illinois College of Medicine
Westlake Community Hospital—Melrose Park
West Suburban Hospital—Oak Park
Woodlawn Hospital—Chicago

COMMITTEE ON DRUGS AND THERAPEUTICS

Vincent A. Costanzo, Jr., Chicago, *Chairman*
John S. Hyde, Oak Park
Martin J. Kaplan, Highland Park
Frank K. Leung, Waukegan
Allan Lorincz, Chicago
Arthur Marks, Fairfield

Consultants:
Joan E. Cummings, Hines
Harold L. Jensen, Flossmoor
Samuel Enloe, Jr., R.Ph., Decatur

Responsibilities and Purposes:

The committee shall meet periodically to review the listing of pharmaceutical products in the IDPA Drug Manual. When it deems it necessary to list new products in the Manual, the committee shall request the Board of Trustees to approve and forward its recommendations to the Illinois Department of Public Aid. Comments or suggestions made by the membership regarding drug products also are reviewed by the committee.

COMMITTEE ON HEALTH PLANNING

Robert M. Vanecko, Chicago, *Chairman*
Martin E. Bruetman, Palos Heights
Robert D. Dooley, Oak Brook
Norris R. Dougherty, Rockford
Albert J. Novotny, Peoria
Mark E. Swislow, Chicago
Constantine J. Tatooles, Evanston

Consultants:
Alfred J. Kiessel, Decatur
David B. Littman, Highland Park
William Marshall, Olympia Fields
Robert Reardon, Bloomington

Auxiliary Representative
Mrs. Wesley Betsill, Springfield

IMGMA Representative
John Potter, Aurora

Responsibilities and Purposes:

The Committee has responsibility for keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The Committee maintains ongoing liaison with the State Planning Agency, the Statewide Health Coordinating Council, the Health Facilities Planning Board and the local health systems agencies. The Committee also monitors health care coalitions in Illinois and reports to the Board on coalition activities.

COMMITTEE FOR THE IMPAIRED PHYSICIAN

L. Michael Newman, Evanston, *Chairman*
Daniel Angres, Lombard
Richard Banta, Rockford
Donald Chatman, Chicago
Violet Eggert, Chicago
Lee Gladstone, Chicago
Thomas M. Iannucci, Chicago Heights
Richard Lee, Peoria
LeRoy Levitt, Chicago
Michael G. Murphy, Belleville
Richard L. Newman, Quincy
Homer Parkhill, Pontiac
Reinhold Schuller, Kankakee
Donald Sellers, Des Plaines
Craig Showalter, Chicago
W. David Steed, Indian Head Park
Herbert Trace, Evanston
William J. Weigel, Aurora

Consultant
Raymond E. Hoffmann, Rockford

Resident Representative
Richard Quinones, Chicago

Responsibilities and Purposes:

The Committee for the Impaired Physician consists of physicians who provide assistance to impaired physicians and those concerned about them for problems related to alcohol or drug dependence, physical disabilities, mental or emotional disturbances. Provides information, sponsors educational programs, offers counseling, conducts interventions, provides monitoring and serves as the recovering physician's advocate. All activities are provided in a confidential and professional manner.

COMMITTEE ON INSURANCE

Dominic J. Alloco, Frankfort
Herbert Epstein, Glencoe
William A. Henry, Springfield
James G. Hull, Belleville
Warren C. Jenkins, Northbrook

Consultants
Lorris M. Bowers, Peoria
Arthur R. Peterson, Chicago
Warren D. Tuttle, Harrisburg

IMGMA Representative
Gerald T. O'Brien, Chicago

Responsibilities and Purposes:

The Committee on Insurance monitors the ISMS-sponsored insurance programs for members. Current policies and new types of insurance programs are evaluated in order to recommend changes that may benefit society members. The Committee works closely with the program's administrator, Corroon & Black, Inc.

COMMITTEE ON LOSS PREVENTION EDUCATION

Donald Aaronson, Chicago, *Chairman*
Randall T. Bellows, Chicago
Norman Brill, Olympia Fields
Sara C. Charles, Chicago
Robert R. Hartman, Jacksonville
Richard M. Vazquez, Chicago

Consultants
Phillip Boren, Carmi
Alfred J. Clementi, Arlington Heights
Donal D. O'Sullivan, Oak Park
Warren D. Tuttle, Harrisburg

Responsibilities and Purposes:

The Committee on Loss Prevention Education seeks to help physicians identify legal dicta and court procedures and the application of these to medical practice. It seeks to enable physician identification of potential problems in various medical procedures and practice settings and effect a change in same. Educational efforts are intended to improve the quality of medical care and prevent law suits.

PEER REVIEW APPEALS COMMITTEE

Boone Brackett, Oak Park, *Chairman*
Harry L. Lewis, Benton
John P. McGee, Glenview
Helen Morrison, Chicago
James Russell, Downers Grove

Responsibilities and Purposes:

This committee serves as the appellate body for cases appealed from local or district peer review committees. Peer review involves the medical review of cases concerning the utilization and quality of medical services, as well as patient relations issues. The committee is the state Society's liaison to local peer review committees and monitors review activities around the state.

PLANNING AND PRIORITIES COMMITTEE

Members of this committee are appointed annually by the ISMS President-Elect.

Responsibilities and Purposes:

The President-Elect shall serve as the chairman of the Committee on Planning and Priorities. This Committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President.

TASK FORCE ON FINANCIAL AID TO MEDICAL STUDENTS

Fred Z. White, Chillicothe, *Chairman*
George Beranek, Chicago
Julian W. Buser, Belleville
Robert C. Hamilton, Chicago
Robert P. Johnson, Springfield
Karl W. Scheribel, Arlington Hts.
Cyril C. Wiggishoff, Chicago

Auxiliary Representative
Diane Hinderliter, Rochelle

Responsibilities and Purposes:

The Task Force on Financial Aid to Medical Students shall be responsible for developing and maintaining a student loan program through the Educational & Scientific Foundation to assist Illinois medical students in meeting financial obligations of an undergraduate medical school program. In particular, this task force shall explore ways and means of raising funds for the development of a student loan program and, through the ISMS Educational and Scientific Foundation, establish guidelines and administration for such a program.

Direct Reporting Committees of the House of Delegates

JUDICIAL PANEL COMMITTEE

	Term Expires
Frank B. Norbury, Jacksonville, *Chairman*	1988
Donald Aaronson, Chicago	1987
Allison Burdick, Jr., Oak Park	1989
Arthur Fischer, Berwyn	1989
Eugene P. Johnson, Casey	1986
Robert H. Lund, Rockford	1990

Responsibilities and Purposes:

The Panel, whose members are nominated by the President and elected by the House of Delegates, adjudicates disputes arising from charges of unethical or illegal practices. The panel accepts appeals after a case has been heard at the county or district level.

Other Appointments and Representatives

REPRESENTATIVES TO STUDENT LOAN FUND BOARD

Jack Gibbs, Canton, *Chairman*
Carl Campanella, Du Quoin
Thomas Schrepfer, Urbana
Karl Scheribel, Arlington Heights, *Alternate*

Responsibilities and Purposes:

ISMS representatives on the Student Loan Fund Board are responsible to the Board of Trustees in matters related to administration of the Student Loan Program operated jointly with the Illinois Agricultural Association.

REPRESENTATIVES TO INA-ISMS JOINT PRACTICE COMMITTEE

Audley F. Connor, Jr., Chicago
Joseph Murphy, Chicago
A. William Schafer, Hinsdale

Responsibilities and Purposes:

The purposes and objectives of the committee shall be to: (1) improve communication between medicine and nursing to enhance joint planning and action; (2) examine roles and functions in medical and nursing practice with definition of new and altered patterns; (3) propose changes in educational patterns and relationships that would enhance the new role functioning of nurses and physicians; (4) define, identify and examine health care needs; (5) address the traditional problems which affect nurse-physician relationships in order to establish enhanced role functioning; and (6) identify and address the ensuing problems related to basic role reorganization.

ISMS REPRESENTATIVES TO OTHER GROUPS

Swanberg Foundation, Quincy
Robert R. Hartman, Jacksonville

Liaison to Ill. Soc. of the Amer. Assoc. of Med. Assts.
Robert R. Hartman, Jacksonville

Ill. Interagency Coun. on Smoking and Disease
Charles L. Swarts, Oak Park

Illinois Medical Records Assoc.
Clifton Reeder, Wilmette

MD Committee on Optometry
Joel Kaplan, Chicago

Illinois Cancer Council
Peter Friedell, Chicago

Citizens Committee for an Illinois Program to Control High Blood Pressure
David Berkson, Chicago

U.S. Pharmacopaeia
Vincent Costanzo, Chicago, *Delegate*
Joseph Skom, Chicago, *Alternate*

ISMS SERVICES

Members of the Illinois State Medical Society benefit from a wide range of services, programs, and publications. These are developed in response to official actions and policies of the House of Delegates and implemented through the Board of Trustees. The headquarters staff has been structured to respond to the directives of the House and the Board and develops and coordinates activities to provide these services. Following is a brief description of the divisional structuring, organization and services of the Society and the headquarters office.

EXECUTIVE OFFICE

Mr. Alexander R. Lerner is Executive Administrator of the Society. The Executive Administrator is responsible for the implementation of established policy, fiscal, budgetary and personnel matters. In this position, the Executive Administrator:

- provides liaison with the Board of Trustees and implements their actions
- is responsible for support and staffing of the House of Delegates
- evaluates legal inquiries for appropriate referral to corporate counsel
- has final authority for management team program planning and implementation
- provides guidance to officers, trustees, committee chairmen and county society officers
- directs activity and organization of staff personnel
- serves as secretary-treasurer for the Illinois State Medical Insurance Services, Inc.

Society programs, issues and activities are coordinated administratively through delegation of managerial authority.

ADMINISTRATION

The Deputy Administrator, Administration, directs and manages activities of the Divisions of Medical Education, Specialty Society Services and Administrative Records. Additionally, direct staff support is provided through the Deputy Administrator for the House of Delegates, Board of Trustees, Executive Committee, Policy Committee, Constitution and Bylaws Committee, the Educational and Scientific Foundation, the Medical Student Section and the Resident Physician Section. Overall provision of services of staff are coordinated through the Deputy Administrator. The Deputy Administrator reports directly to the Executive Administrator and assumes additional responsibility at the direction of the Executive Administrator.

Medical Education

The Society monitors changes in medical education, postgraduate requirements for licensure and accreditation procedures. Educational matters are addressed through staff services to the Illinois Council on Continuing Medical Education, the ISMS Council on Education and Manpower and the Committee on CME Accreditation. In addition, staff services are provided to the Task Force on Financial Aid to Medical Students and the Committee on Loss Prevention Education. Educational matters are addressed through the following services:

- ICCME—The Illinois Council on Continuing Medical Education is jointly sponsored by ISMS and the State's eight medical schools, the purpose of which is to encourage the development of quality CME through formal learning programs, educational consultation and educationally related research.
- Council on Education and Manpower—This Council considers educational issues which affect the medical manpower and licensure needs of Illinois.
- Committee on CME Accreditation—This Committee deliberates on the periodic accreditation status of Illinois CME sponsors and makes accreditation decisions.
- Committee on Loss Prevention Education—This Committee develops educational programs for Illinois physicians on malpractice/loss prevention, and works to publicize the need for organized medicine to reduce exposure to medical malpractice litigation and is responsible for bimonthly publication of the "Antidote" claims flyer.
- Task Force on Financial Aid to Medical Students. This Task Force is responsible for developing and maintaining the ISMS student loan program through the Educational and Scientific Foundation and exploring possible ways to raise funds for the development of the student loan program.
- The Medical Student Loan Fund Program is a joint effort of ISMS and the Illinois Agricultural Association. The Medical Student Loan Fund Board screens students whose college grades or MCAT scores are marginal and recommends special consideration by the UI College of Medicine in selected cases. In return, the student promises to practice in a rural community needing a physician for four or five years after graduation. The program also makes low interest loans available to students.
- A new loan program has been instituted through the ISMS Educational and Scientific Foundation, supported by a dues allocation and other grants. This program was initiated in 1983 through the Task Force on Financial Aid to Medical Students.

Administrative Records

The Division of Administrative Records is charged with responsibility for maintaining the listing of official actions and positions taken by ISMS' House of Delegates and Board of Trustees. The minutes and official transcriptions are maintained by this Division. In addition, records of all appointments and nominations are kept, as well as any other official documents. Staff services are provided to the Committee on Committees.

Services to Specialty Societies

Administrative services are provided to specialty societies and affiliated groups on a cost-allocated basis by the Division of Specialty Societies. These include office management, meeting arrangements, membership promotion and record maintenance, newsletter publishing, legislative representation, dues collection and accounting services. Staff and other services are provided to the Council on Affiliate Societies.

PLANNING AND PROGRAM DEVELOPMENT

The responsibilities of the Associate Administrator for Planning and Program Development are designed to coordinate and execute a broad range of programs across divisional and organizational lines. These responsibilities include:

- provide staff support for the Planning & Priorities Committee and identification of major issues affecting physicians in their practice;
- develop programs that meet the informational needs for the physician membership and the public on the position of ISMS on important medical issues; and
- provide consultation and coordination to ISMS divisions and affiliated organizations on planning and program development.

In addition, the Associate Administrator for Planning and Program Development oversees and coordinates the activities of Medical Services and Professional Relations.

Medical Services

The Division of Medical Services is responsible for initiating, supporting, monitoring and implementing activities related to health care facilities, alcohol and drug misuse, discipline of physicians, public and mental health, physician impairment, medical-legal issues, school and child health, maternal welfare, aging, blood banking, sports medicine, and emergency medical services. These responsibilities are carried out through the following:

- council and committee activities, where members and outside consultants examine, debate and formulate ideas and recommendations for consideration by the Board of Trustees;
- development of educational materials and programs for the physician and his patient;
- liaison activities with governmental, professional and consumer organizations to promote and defend ISMS policies or concerns and educate others about issues important to physicians.

The following Councils and their Committees are supported by staff of this Division: Committee for the Impaired Physician, Judicial Panel, Medical-Legal Council, Council on Medical Services, Council on Mental Health & Addiction, Peer Review Appeals Committee, Committee on Workers Compensation, Maternal Welfare Committee, Committee on Alcoholism and Drug Dependence, Committee on Sports Medicine, and Committee on Laboratory Services. Ongoing liaison is conducted with various agencies to keep abreast of current developments and items of mutual concern.

In addition, the Division administers a state grant from the new Department of Alcoholism and Substance Abuse to create materials and conduct educational programs on substance abuse throughout 1985-86.

Professional Relations

Professional Relations provides staff support for the Illinois State Medical Society Auxiliary and additional support, when needed, to the Deputy Administrator, Administration, and the Associate Administrator for Planning and Program Development, for the Illinois Delegation to AMA and the Medical Student and Resident Physicians Sections.

COMMUNICATIONS

Under direction of the Assistant Administrator, Communications, the membership, marketing, field services, public relations and publications activities are coordinated. Staff in these areas:

- provide information on a broad range of issues that affect physicians in their practices;
- provide a broad range of information to the media and public on the position of ISMS on important medical issues;
- provide consultation and coordination to other ISMS divisions in the area of membership mailings, and distribution of membership and public information;
- provide information and services to hospital medical staffs;
- retain, recruit, promote and process membership in organized medicine at the county, state and AMA levels and
- educate physicians on the professional liability climate in general, and on the value of the Exchange in particular.

Field Services

Staff in this area:

- provide assistance and information to ISMS members on a broad range of issues by working with district trustees, county medical society leaders and executives, hospital medical staff leaders and ISMIE Network Representatives;
- coordinate the ISMS President's Tour, in which the president visits county medical society meetings and local media to discuss society views and activities;
- provide staff support to the ISMS Hospital Medical Staff Section;
- publish *Trustee Report,* a newsletter issued periodically which communicates important information on ISMS activities to local physician leaders; and
- promote and assist member activity to further ISMS legislative and governmental goals, including participation in IMPAC and the Key Contact program.

Publications

Staff of the Division of Publications work to provide information to the ISMS membership through various publications. Services include promotional design and layout, editorial and creative work for such publications as:

- The *Illinois Medical Journal* which is published monthly to keep members aware of clinical, economic, legal, and political events;
- *Action Report* which is published peri-

odically to inform members of Society activities and present news in the area of socio-economics;

- *On the Legislative Scene* which is distributed on request to ISMS members during the General Assembly session to offer a status report on pending legislation of importance to Illinois physicians;
- *The Trustee Report* which is published periodically to communicate news of ISMS activities to county medical society officers, delegates, alternate delegates and executives; and
- *AID (Athletics, Injury and Disease)* which offers sports-medicine information to junior and senior high school coaches and trainers in Illinois to help them prevent, recognize and triage sports-related injuries and illnesses.

Society staff members produce several publications for the Illinois State Medical Inter-Insurance Exchange, including:

- *Exchange Commentary* which serves as ISMIE's main method of communicating with its policyholders;
- *Antidote* which is published jointly with the ISMS Committee on Loss Prevention and discusses case studies designed to help physicians avoid the situations that can lead to malpractice suits; and
- The ISMIE *Annual Report* which presents end-of-year financial data and operating statistics to Exchange policyholders.

ISMS Staff assists specialty societies and other affiliate groups in producing their newsletters and other publications. Assistance also is provided to the ISMS Auxiliary in the publication of *Pulse of the ISMS Auxiliary.*

Activities of the Division are directed by the Society's Publications Committee and the *IMJ* Editorial Board. Additional publication production services are provided for subsidiary organizations.

Public Relations

The ISMS Public Relations Division provides information to news media representatives and the public on health care issues. Building the visibility and image of Illinois' medical profession is the division's overall goal. Its activities include regular, frequent development of:

- news releases and related media information voicing ISMS public policy views;
- speeches for use by Illinois physicians in making presentations to a variety of public audiences;
- "white papers", viewpoint essays and brochures on key health care issues;
- public service announcements for broadcast by Illinois radio and television stations; and
- public information resource materials for use by county medical societies.

On a daily basis, the Public Relations Division handles all ISMS media requests and monitors coverage of health care-related topics by Illinois media outlets. Staff is also available to conduct spokesperson training workshops for those physicians speaking out on behalf of ISMS. The division provides services and programming for the Council of Public Relations and Member Services.

FINANCE AND MANAGEMENT SERVICES

The Associate Administrator, Finance, is responsible for the direction of the financial management activities, computer services, meeting services, membership programs, sponsored insurance programs, the benevolence fund, office services and human resources management. This group is responsible for management of the physical premises occupied by the Society and maintains liaison with the various auditing firms.

Financial Management

Financial management services are conducted under policies established by the Board of Trustees and Finance Committee. These activities include financial reporting, maintaining financial records for receipts and disbursements, budgeting, monitoring investments and securing assets.

Computer Services

As an integral part of financial management, electronic data processing capabilities are maintained to provide a cost-effective method to:

- maintain membership and policyholder records;
- provide central Society dues billings and collection for county medical societies;
- provide invoicing for professional liability premiums;
- maintain records and statistics on professional liability claims, policyholder files and other insurance related information;
- process financial records; and
- provide word processing capabilities.

Human Resources

Staffing for the Society is coordinated under Human Resources for recruiting, payroll, employee benefits, and maintenance of personnel records

Meeting Services and Membership Programs

A number of programs and services are provided to Society members or sponsored for their benefit. These include the 50-Year-Club, physician recruitment, meeting services and travel programs.

- The 50-Year-Club consists of physicians who graduated from medical school more than 50 years ago. An annual luncheon gives these members an opportunity to renew friendships.
- ISMS meeting services include provision of services for assemblies of the House of Delegates and Board of Trustees. Councils and committees meet in the headquarters office.
- Society-sponsored travel programs enable members to enjoy luxury cruises and tours. Qualified tour agencies are screened for professional, non-regimented trips.

Medical students and residents have formed affiliate sections within the Society. ISMS also conducts several programs for new physicians and those seeking either a medical education or an opportunity to practice in Illinois.

- The Physician Recruitment Program seeks to link communities in need of a physician with those seeking practice opportunities.
- The MECO (Medical Education Community Orientation) program seeks to encourage students to select careers in primary care.

Office Services

Office services include building services for staff and physician meetings, mail and supply services, switchboard and receptionist services for the Society and Insurance operations. Facility maintenance, telephone service and centralized purchasing are also under the office service function.

Sponsored Insurance Programs

Staff services are provided for the ISMS Insurance Committee which works through an independent broker as directed by the Board of Trustees, in sponsoring various insurance programs for the benefit of the membership. Each program has been scrutinized for quality and economy. A brief synopsis of each program follows:

Group Term Life Insurance

The group term life insurance program is underwritten by the North American Com-

pany for Life and Health Insurance. It offers:

- $25,000 to $1 million in level term life insurance
- a built-in waiver of premium
- availability to members, their spouses and employees under age 65
- coverage to $5,000 for members' children
- non-cancellable, guaranteed renewability to age 100
- conversion to permanent individual policy guaranteed to age 65

Group Disability Income Protection Program

The group disability income protection program is underwritten by the Commercial Insurance Company. It provides:

- $500-$3,000/month for total disability
- coverage renewable to age 70
- benefit period options of lifetime accident and sickness
- payable (1) to age 65; (2) for seven years; (3) five year accident and sickness payable for 2 years
- available to members and authorized employees or insured members to age 55
- benefits payable regardless of other insurance
- no restrictive riders attached after issuance
- individual coverage cannot be terminated

Professional Overhead Expense Plan

This plan is underwritten by the Hartford Accident and Indemnity Company and provides:

- $500-$5,000/month coverage
- office overhead expenses paid to maximum benefit selected beginning with 31st day of total disability
- benefits payable to 24 months regardless of other insurance
- accumulation benefit provided
- guaranteed issue for qualified new members under age 40 who apply within 60 days of effective date of membership
- available to all members under age 65 in full time practice
- rent, utilities, employee salaries and monthly *pro rata* of specified annual fixed expenses customary to the profession
- premiums deductible for individuals and partnerships under Revenue Ruling 55-264

The plan does not cover personal income, salaries for other physicians, principal payments on debts, implements, pharmaceutical products and personal insurance premiums.

Group Major Medical

The group major medical plan is underwritten by Commercial Insurance Company. It provides that the insured select a calendar year deductible of $500, $1,000 or $2,000 which applies to each insured person. It will then pay 80% of reasonable and customary expenses such as:

- semi-private room in the hospital
- hospital supplies and services, physician services, anesthetists, diagnostic lab and x-ray, registered nurses, ambulance services, prescription drugs and medicines, physiotherapy, therapeutic equipment rentals, artificial limbs, oxygen and blood.

The plan has a maximum out-of-pocket expense of $4,000 plus deductible and pays up to a lifetime maximum of $500,000 on health benefits. The plan is available to all members and qualified employees of insured members under age 55, and can be renewed up to age 65.

Medicare Supplement

The Medicare supplement plan is underwritten by the Hartford Accident & Indemnity Company. It covers charges for the following, incurred either as in-patient or out-patient:

- annual Medicare deductibles
- semi-private room and board
- diagnostic x-rays, lab tests, doctor's services, general nursing, drugs, anesthesia and many other hospital, medical and surgical services which are partially covered by Medicare.

The plan is available to members 65 and over and once members are enrolled, their spouses may be insured on reaching age 65. Eligible applicants are guaranteed acceptance subject to a pre-existing condition limitation.

Hospital Indemnity Plan

The Hartford Accident and Indemnity Company underwrites the ISMS-sponsored hospital indemnity plan. Available plans provide benefits of $27.50, $55.00, $110.00 or $165 per day of hospital confinement. Benefits are also:

- initiated with first day of confinement
- payable to 365 days for each cause of confinement
- automatically doubled for hospital stays due to cancer or confinement in an ICU for persons under age 65
- payable regardless of other insurance

All members, their employees and families may participate. Acceptance of eligible applicants during special enrollment periods is guaranteed, subject to a pre-existing conditions limitation.

Workers' Compensation

Policies issued by the Casualty Reciprocal Exchange, a member of the Dodson Insurance group, are administered under the Dodson Savings Plan. Specific aspects include the following:

- return declared at the end of each premium year on the basis of loss experience—savings are returned to policyholders
- rates standard and approved for class of employment
- savings paid as earned within approximately 90 days of policy expiration or on completion of payroll audits

Accidental Death and Dismemberment

An accidental death and dismemberment plan is underwritten by the Hartford Accident & Indemnity Company. It provides coverage:

- for members, their spouses, children and employees
- a 24-hour business and pleasure coverage from $25,000 to $250,000
- renewable to age 70

GOVERNMENTAL AFFAIRS

The Division of Governmental Affairs, under direction of the Assistant Administrator for Governmental Affairs, provides staff services for the Governmental Affairs Council, Public Affairs Committee, IMPAC, and liaison to various governmental agencies. The Society's legislative program is conducted under direction of the Governmental Affairs Council. All state and national health legislation is monitored. Society staff forward bills to physician members with pertinent expertise for review and comment. Legislative representatives express the ISMS position to legislators, while also continually monitoring amendments to bills of interest to the medical profession. The Division also coordinates physician testimony before legislative committees.

Additional input and citizen involvement are developed through the Key Contact Program and public affairs activity.

- The Key Contact Program is a network of physicians or spouses who are relatives, friends or campaign supporters of Illinois legislators, who advise legislators on health legislation.
- Public Affairs activity includes sponsorship of speakers at Society meetings and liaison with government agencies. It encourages grassroots involvement in the political process. Also, the Division coordinates activities of the Illinois State Medical Society Political Action Committee.

Staff services are provided through both the Chicago headquarters and the Springfield Regional Office.

HEALTH CARE FINANCE

The Division of Health Care Finance, under direction of the Assistant Administrator for Health Care Finance, concerns itself primarily with economic issues facing the profession. Staff services are provided the Council on Economics, the Committee on Health Planning, the Third Party Payment Processes Committee, and the Committee on Drugs and Therapeutics. Under the direction of the Board, various services are provided to members with questions or problems in the following aspects of health care finance:

- Medicaid, Medicare & CHAMPUS—Services are provided in representation of member interests of a policy nature. Liaison is provided with the Illinois Department of Public Aid and the Medicare Part B carrier to assure that member concerns are represented when policy changes are considered. Specific assistance is provided for members with inquiries about third party payor policies.
- Health Planning—Actions of the Statewide Health Coordinating Council, Illinois Health Facilities Planning Board (CON), and local Health Systems Agencies are closely monitored and Society positions are expressed.
- Third Party Payor and Economic Activity—The Division is directly involved in liaison activities with insurance carriers and government bodies on all economic issues relating to the practice of medicine, *e.g.*, hold harmless agreements and determinations of medical necessity. The Division performs research, offers speakers and monitors the development of new reimbursement and health care delivery systems for the membership, *e.g.*, Diagnosis Related Groups (DRGs), Preferred Provider Organizations (PPOs), Exclusive Provider Organizations (EPOs), Utilization Review (Private and Peer Review Organizations [PROs]) and HMOs/IPAs.
- Cost containment activities—Various cost containment concerns are monitored, such as the Illinois Health Care Cost Containment Council, and the Illinois Hospital Service Procurement Advisory Board, to assure appropriate medical issues are included.
- Health Data Systems—Government requirements for statistical information on health care and planning are monitored.
- Drugs and Therapeutics—The Division provides staff assistance to the ISMS Committee on Drugs and Therapeutics, which reviews new drug products and makes recommendations on products for inclusion in the IDPA Drug Manual for Public Aid recipients.
- Office of Contractual Services—ISMS provides free of charge to any member, a summary of the major terms and conditions of proposed PPO, HMO, and IPA contracts. The summary does not advise physicians to sign or not sign such contracts, nor is it intended to be legal advice. However, the summary explains in detail the major provisions of proposed contracts and specifies how, if at all, a physician's professional liability insurance may be affected. Members wishing such a review may submit two copies of the proposed contract and any documents incorporated by reference (*e.g.*, bylaws, UR agreements) to the ISMS offices.

DIRECTORY OF MANAGEMENT STAFF PERSONNEL

The Illinois State Medical Society headquarters office is located at Twenty North Michigan Avenue, Suite 700, Chicago, Illinois 60602. The telephone number is (312) 782-1654. In addition, a Springfield office is maintained at 701 South Second Street, Springfield, Illinois 62704, telephone (217) 528-5609.

Below are the key staff identified by managerial areas in keeping with the above itemization of responsibilities. Following the name of the individual is a direct dial telephone number at the headquarters office. Any staff member can also be reached through the general information number (312) 782-1654.

EXECUTIVE OFFICE

Alexander R. Lerner, Executive Administrator 580-2412

ADMINISTRATION

Richard A. Ott, Deputy Administrator 580-2460
Perry L. Smithers, Executive Assistant 580-2416
Thomas Pearson, Ed.D., Director, Medical Education 580-2445
Kathleen A. Pirages, M.S.Ed., Assistant Director, Medical Education ... 580-2481
Rose Anne Christiansen, Director, Administrative Records 580-2470
Leslie Freeman, Director, Specialty Society Services 580-2480

PLANNING AND PROGRAM DEVELOPMENT

Donald A. Udstuen, Associate Administrator 580-2418
Cheryl Koos, Assistant Director, Professional Relations 580-2493
Larry Boress, Director, Medical Services 580-2435

COMMUNICATIONS

Linda Hudson, Assistant Administrator 580-2449
Suzanne W. Nelson, Director, Public Relations 580-2423
Gary Fitzgerald, Director, Field Services 580-2474
Martin Masel, Field Representative 580-2473
Daniel R. Nash, Marketing Representative 580-2411
Edward Stecki, Director, Publications 580-2456
Mariann Stephens, Assistant Director, Publications 580-2419

FINANCE AND MANAGEMENT SERVICES

Lawrence Deidrick, Associate Administrator 580-2420
Elizabeth Duffy, Director, Meeting Services and Membership Programs 580-2472
James Giese, Director, Finance 580-2454
Diana Role, Director, Computer Services 580-2488
Alan Allphin, Internal Auditor 580-2432
Debra Nelson, Human Resources Coordinator 580-2430

GOVERNMENTAL AFFAIRS

Jeffrey M. Holden, Assistant Administrator 580-2440
James Tierney, Assistant Director 580-2484
Springfield Regional Office 217/528-5609

HEALTH CARE FINANCE

Robert K. Burger, Assistant Administrator 580-2462
Ken Ryan, Assistant Director .. 580-2491
Andrew Melczer, Health Economist 580-2468

The Educational & Scientific Foundation

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of clinical science through:

1) The initiation of scientific and medical research activities.

2) The collection, evaluation and dissemination of the results of research activities to the public.

3) The implementation and management of projects related to medicine for individuals, or organizations seeking to inform or educate others, or to improve their own knowledge.

The Foundation is a distinct corporate entity which has an interlocking Board with the Illinois State Medical Society. It is staffed through ISMS headquarters.

The ISMS immediate past president serves as chairman of the Foundation's Board of Directors.

Board of Directors

Robert C. Hamilton, Chicago, *Chairman*
Alfred J. Clementi, Arlington Heights
Jere E. Freidheim, Chicago
Morgan M. Meyer, Lombard
Ronald G. Welch, Belleville

Illinois Council on Continuing Medical Education

This Council was created by the Illinois State Medical Society, in cooperation with the state's eight medical schools, to fulfill these purposes: (a) encourage and assist in the development of continuing medical education programs for Illinois physicians that will enhance patient care; (b) study and encourage development of new educational methods, techniques, systems, etc.; (c) assist learning sources to identify the educational needs of Illinois physicians; and (d) stimulate, motivate, and encourage physicians at all levels throughout the state to participate in formal continuing educational programs.

ICCME was proposed by Dr. Edward W. Cannady in his 1969 inaugural address as president of ISMS. Following careful study, the 1970 House of Delegates approved the plan in principle. The next president, Dr. J. Ernest Breed, vigorously pursued the idea; after the 1971 House of Delegates voted initial funding, he also served as chairman of the organizing committee.

ICCME was officially chartered by the state as a nonprofit educational organization in May, 1972, and began operations in September, 1972. Financial support of the Council is provided primarily by ISMS members' dues.

ICCME unites the resources of the Illinois State Medical Society and the educational resources of the state's medical schools; it serves *all* interests concerned with CME and thus provides a crucial channel of communication to coordinate the efficient use of all available resources.

Current Major Activities

1. Sponsor an annual Congress on Continuing Medical Education, to involve all elements of the Illinois health care system in the Council's work.
2. On behalf of ISMS, perform site visits for accreditation of intrastate CME including advice on preparing to apply for accreditation.
3. Advise hospitals and other organizations on effective CME planning and organization.
4. Organize workshops on techniques of CME—including an unusual "Seminar on CME Leadership" for leaders of hospital medical staffs and medical societies.
5. Develop and publish CME planning aids that offer practical advice and important background on effective organization of CME. For all items now available, request "The Illinois Handbook on CME Planning — Catalog/Order Form." All publications are available to ISMS members at a 50% discount. To obtain a copy of the Catalog/Order Form just indicate this on your prescription form and mail to ICCME, Twenty North Michigan Ave., Suite 700, Chicago, Illinois 60602.
6. Prepare a monthly calendar of Illinois CME activities for *IMJ*.
7. Plan and conduct research studies that contribute to the improvement of CME methods.

Organization & Governance

Members of the ISMS Executive Committee serve as legal members of the ICCME Corporation, set basic policy, and elect the Board of Directors.

The affairs, property, and business of the Council are managed by a Board of Directors comprised of nine practicing physicians representing the state medical society and eight academic physicians/educators, one selected by each dean of an Illinois medical school.

Board of Directors

Harold A. Paul, M.D., M.P.H., *President*
Robert L. Prentice, M.D., *Vice-President*
Michael H.M. Dykes, M.D., M.Ed., *Secretary*
Lawrence L. Hirsch, M.D., *Treasurer*
Ben B. Blivaiss, Ph.D., North Chicago
H. Contance Bonbrest, M.D., Chicago
Dean R. Bordeaux, M.D., M.A., (Educ.), Peoria
Ernesto B. Eusebio, M.D., Springfield
Allan L. Goslin, M.D., Streator
Terry F. Hatch, M.D., Urbana
Marten M. Kernis, Ph.D., Chicago
Julius S. Newman, M.D., Aurora
Charles E. Osborne, Ed.D., Springfield
Ward E. Perrin, D.O., F.A.C.O.I., Chicago
Donald F. Pochyly, M.D., M.Ed., Hines
Francis H. Straus, II, M.D., Chicago
Cyril C. Wiggishoff, M.D., Chicago

Panel of Accreditation Site Visit Surveyors

Serving as Surveyors are Board Members of the Illinois Council on Continuing Medical Education and others chosen by the ICCME Board who meet criteria adopted by the ISMS Board of Trustees, March 31, 1979. ICCME does *not* make accreditation decisions, neither individual Board Members nor the Board collectively. Rather, the Survey Team's role is analogous to that of the physician who performs a physical examination on a potential purchaser of life insurance: to ascertain and report the facts, leaving to the underwriter the actuarial decision on granting insurance. The Survey Team makes a judgment on each of the seven "Illinois Criteria," on the basis of point values prescribed by the ISMS Committee on CME Accreditation, as well as the Team's conversation with the Sponsor. Names of individuals serving on the Panel of Surveyors, in addition to members of the ICCME Board, are shown in the list which follows immediately (all are physicians unless otherwise indicated):

Philip D. Anderson, M.D., Ph.D.
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Henri S. Havdala
Thomas O. Henderson, Ph.D.
Eugene T. Hoban
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Charles J. Weigel
Ruth Wharton
Fred Z. White, M.D., M.A.
George T. Wilkins
Roger A. Wujek
William H. Young, Ed.D.

Illinois Foundation for Medical Care

The Illinois Foundation for Medical Care (IFMC) is a not-for-profit corporation established in 1971 by action of the House of Delegates. Under revised bylaws adopted June, 1977, IFMC is operated under direction of a Board of Directors elected annually by the ISMS Board of Trustees.

IFMC Board of Directors

Joseph Sherrick, Chicago, *President*
Robert P. Johnson, Springfield, *Vice-President*
James Laidlaw, Champaign, *Secretary-Treasurer*
Audley F. Connor, Jr., Chicago
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Robert Prentice, Springfield

Illinois Society, American Association of Medical Assistants

The American Association of Medical Assistants is a national, non-profit organization dedicated to the professional advancement of medical assistants. This tri-level structure—similar to AMA—encompasses local, state and national affiliation.

Membership in the Illinois Society, AAMA, is open to medical assistants, office nurses, technicians, secretaries, bookkeepers and clerks performing administrative and/or clinical duties under the direct supervision of a physician. College students attending medical assistant programs are encouraged to belong. Physician advisors at all three levels assist with educational endeavors.

The state society's numerous professional, educational programs in various parts of the state offer continuing education units (CEU) to its participants. Some of the major programs are: travel courses, regional seminars, annual symposium, personal development day and the all day workshop held in conjunction with Chicago Medical Society's Midwest Clinical Conference. The annual three day meeting in April includes excellent lectures, study programs and the culmination of association business during the house of delegates session.

The American Association of Medical Assistants encourages advancement of medical assistants by offering a certification examination designed to evaluate professional competency. Local chapters, in addition to their regularly scheduled monthly educational programs, conduct preparatory classes in terminology, physiology, anatomy, human relations, patient contact, medical law and ethics, communications, bookkeeping, insurance, administrative procedures, laboratory orientation and collection methods. The certification examination is administered twice a year.

The medical assistant may become a Certified Medical Assistant (CMA) by successfully passing the special board examination and meeting qualifying criteria of the American Association of Medical Assistants. For further information about this program contact the American Association of Medical Assistants, 20 North Wacker Drive, Chicago IL 60606.

Members interested in independent continuing education through a "home study" program may purchase and utilize audio cassettes and workbooks. The president of the Illinois Society communicates, via the "Executive Memo" (a monthly publication), with over 400 members giving pertinent information of current activities.

A quarterly publication "The Illini Cardinal" concentrates on educational topics and is available to all members without additional cost. "The Professional Medical Assistant," the official bi-monthly journal of the association, is largely devoted to original articles written for medical assistants by their peers or other professionals in related fields. It is an automatic benefit of membership, although subscriptions are available for nonmembers. There are many other benefits available (*i.e.*, group insurance). During the Annual Meeting of AAMA each Fall, a variety of experts in medical and related fields address participants during educational programs and workshops.

Monthly educational meetings are scheduled in the following chapters: Cook County-Chicago (Downtown), Southwest Suburban (Oak Lawn), Northwest (Arlington Heights), West Cook (River Grove), Cook County South (Oak Forest), Aux Plaines (Oak Park), DeKalb (Sycamore), LaSalle, Macon (Decatur), McLean (Bloomington), Peoria, Rock Island, St. Clair (Belleville), Spoon River Valley (Canton), and Vermilion (Danville). Physicians in these areas are asked to encourage their medical assistants to join the association and actively participate in the selection of educational programs that will enable the members to become better medical assistants.

For membership information please contact: Ehlma Garcia, CMA, EMT-A, 6134 S. Tripp, Chicago IL 60629 or Anna Cannon, EMT-A, 7443 S. Luella Ave., Chicago, IL 60649.

Officers

President: Ehlma Garcia, CMA, EMT-A, Chicago
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1st Vice President: Cheryl Hutchison, CMA, Granite City
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Physician Advisors

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Illinois State Medical Insurance Services, Inc.

Illinois State Medical Insurance Services, Inc., is an Illinois corporation, formed in March 1976, the capital stock of which is owned by the Illinois State Medical Society. It currently acts as Attorney-in-Fact for the Illinois State Medical Inter-Insurance Exchange.

The Inter-Insurance Exchange was organized as an insurance reciprocal to provide comprehensive professional liability insurance for Illinois physicians. Membership in the Exchange is limited to members of the Illinois State Medical Society. The Exchange is chartered under the laws of Illinois and functions under the Illinois Insurance Code.

Insurance Services provides management and underwriting services required for operation of the insurance business of the Exchange. It does so under Power-of-Attorney granted it by the Exchange in a management agreement and by each member of the Exchange through application for membership. Under the management agreement the Board of Governors of the Exchange prescribes policy to be followed in the conduct of the business. Within these policy guidelines Insurance Services provides management by accepting or rejecting applications, determining the form of insurance policies, and handling and disposing of claims. Insurance Services is compensated by the Exchange on the basis of expense reimbursement.

As a wholly-owned subsidiary, ISMIS provides certain services through ISMS on a shared basis. These shared services are on a direct cost reimbursement basis. Insurance Services itself includes four principal divisions: Underwriting, Claims, Medical Director and Administrative Services. In addition, shared services support is provided by ISMS through the Divisions of Administration, Marketing-Public Relations, Publications, Education, Governmental Affairs, Computer Services, Personnel, Finance and Accounting.

Offices of Illinois State Medical Insurance Services, Inc., are at Twenty North Michigan Avenue, Suite 700 Chicago, Illinois 60602 (312/782-2749).

Board of Directors

Warren D. Tuttle, M.D. *Chairman*
Phillip D. Boren, M.D.
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Officers

David R. Cole, *President*
Alexander R. Lerner, *Secretary-Treasurer*
Henry Nussbaum, *Vice President*

ISMS Auxiliary

The Illinois State Medical Society Auxiliary is a unique organization composed entirely of physicians' spouses who give their time and talents to promote health awareness, support medical legislation, and assist organized medicine. Auxiliary members raise funds for medical student loans, benevolence and for medical research and education through the American Medical Association Education and Research Foundation (AMA-ERF). Through AMA-ERF, we encourage a sense of giving and work for the support of quality medical education.

The Illinois State Medical Society Auxiliary had its inception in the parlor car of a speeding train in 1927. Dr. and Mrs. G. Henry Mundt were returning from the AMA meeting in Washington, D. C. and had learned of the existence of the AMAA and of 22 functioning state auxiliaries. Mrs. Mundt was persuaded to undertake the task of organizing an auxiliary in Illinois and to seek the approval of the Illinois State Medical Society's House of Delegates. On May 31, 1927, The ISMS House of Delegates endorsed the organization of an auxiliary in Illinois and urged the county societies to assist in promoting auxiliary membership.

The first formal meeting of the Auxiliary was held at the LeClaire Hotel in Moline on June 2, 1927 with 25 members present. In 1928, the organization became permanent. Today, we have a membership of over 2,000 and can look with pride on the auxiliary's accomplishments.

We have striven to educate the public on cost effective benefits of preventive health through all segments of our comprehensive Shape Up for Life Program. The auxiliary has instituted a large number of successful community health programs (*e.g.*, vial of life, nutrition, physical fitness, stress management, child seat belt safety, immunization, and substance abuse awareness). This year, we are focusing on the prevention of teen suicide, child and sexual abuse, and programs to help the elderly. We form coalitions with other community groups and network with organizations to gain their expertise and to lend ours.

The Auxiliary has been very active with legislation during the past year. We initiated the legislative internship program and have become quite knowledgeable in lobbying techniques. We also provide information on health-related legislation and are part of a legislative alert system. In an effort to have the auxiliary expand activities in the area of support for the physician's family, we have formed a family advocacy program to address family problems unique to the medical profession, including impairment and malpractice.

Being part of a federation allows us to attend national meetings for leadership training and education. We encourage our county presidents-elect to take advantage of attending AMA Auxiliary Confluence in October. All members receive FACETS, a quarterly magazine to keep us abreast of other state activities and to keep us informed.

We communicate throughout Illinois with PULSE and a monthly letter to the county presidents from the President.

Mary Kay McPhee, 1985-86 AMAA president, has been quoted as saying: "Our stated mission is to help improve the health and quality of life. Our private mission is our own members. They are all too frequently experiencing distress and disruption. It is not enough for us to cultivate the public fields alone—we must also cultivate our private gardens. We shall remain the first line support for our physician partners."

Officers

President
Mrs. Thomas Meirink, Belleville

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Mrs. Alex J. Spadoni, Hinsdale

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(Membership Coordinator)
Mrs. Wayne Kassel, Joliet

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(Program and Project Bank Coordinator)
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AMA-ERF
Mrs. Alfred Kiessel, Decatur

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Boutique Coordinator
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Finance
Mrs. Robert Webb, Edwardsville
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Mrs. Wesley Betsill, Springfield
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Members-At-Large
Mrs. Ronald Severino, Wheaton
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Public Relations
Mrs. John Leyland, East Peoria
RP/MSS Liaison
Mrs. Richard Leu
Widows & Spouses of Retired Physicians
Mrs. Earl Klaren, Libertyville

Consultants

Cults
Mrs. George Olander, Lake Forest
Exceptional Person Awareness
Mrs. Gene Hoerr, Peoria
International Health
Mrs. Sadiq Mohyuddin, Godfrey
Organ Donation
Mrs. James Monahan, Waukegan
Scrapbook
Mrs. Julian Buser, Belleville

Representatives to ISMS Councils and Committees

Alcoholism & Drug Dependence
Mrs. Neville White, Springfield
Benevolence
Mrs. Louis Tarsinos, Princeton
Economics
Mrs. Raymond Hoffmann, Rockford
Education & Manpower
Mrs. Alfred Kiessel, Decatur
Governmental Affairs
Mrs. Alan Taylor, Danville
Health Planning
Mrs. Wesley Betsill, Springfield
Medical-Legal
Mrs. Robert Reardon, Bloomington
Medical Services
Mrs. Robert Chapman, Belleville
Mental Health & Addiction
Mrs. Alex Spadoni, Hinsdale
Public Affairs
Mrs. Thomas Meirink, Belleville
Public Relations & Membership Services
Mrs. Wayne Kassel, Joliet
Sports Medicine
Mrs. Harold Keegan, Kankakee
Task Force on Financial Assistance to Medical Students
Mrs. Don Hinderliter, Rochelle

ISMS Hospital Medical Staff Section

Raymond A. Dieter, Jr., Glen Ellyn, *Chairman*
Joseph L. Murphy, Chicago, *Vice-Chairman*
Allan L. Goslin, Streator, *Secretary*
Thomas C. Malvar, Chicago, *Treasurer*
Silvana Y. Menendez, Belleville, *Delegate*
Dennis M. Brown, Schaumburg, *Alternate Delegate*
Warren D. Tuttle, Harrisburg, *At-Large Member*
Lawrence A. Stone, Des Plaines, *At-Large Member*
Albino T. Bismonte, Gurnee, *At-Large Member*
Jaroslav F. Neskodny, Berwyn, *At-Large Member*

Responsibilities and Purposes

The purposes of the Hospital Medical Staff Section shall be to provide representation of hospital medical staffs within the ISMS. The Section will also support the purposes of the ISMS, as stated in its Constitution. Membership in the Section consists of ISMS members who have been elected to represent their individual hospital medical staffs.

ISMS Medical Student Section

Lauren Baker, *Chairman*
David O'Brien, *Vice Chairman*
Jodie Roy, *Secretary*
Gail Herman, *Delegate*
Lynn Malanfant, *Alternate Delegate*
Blaine Markee, *MECO Coordinator*

School Representatives

Chicago College of Osteopathic Medicine
Mark Dobbertien, Delegate
Craig Matheson, Alternate
Chicago Medical School
Blaine Markee, Delegate
Kenneth H. Herrmann, Alternate
Loyola University
Carl Coppola, Delegate
N. Mark Bates, Alternate
Northwestern University Medical School
Gregory M. Gullahorn, Delegate
Phil Myers, Alternate
Rush Medical College
Eileen Mahoney, Delegate
Dipali Apte, Alternate
SIU School of Medicine
Scott Green, Delegate
University of Chicago
Mark Kadowaki, Delegate
Jennifer Souders, Alternate
University of Illinois-Chicago
Jack Whitney, Delegate
Howard B. Chodash, Alternate
University of Illinois-Champaign/Urbana
Hal Bennett, Delegate
University of Illinois-Peoria
Donald Brady, Delegate
Aaron Siegel, Alternate
University of Illinois-Rockford
Nancy Zamora, Delegate
Lynn Malanfant, Alternate

Council Representatives

Thomas Zusag, Economics
Mark Dobbertien, Governmental Affairs
J. Michael Tuchek, Medical-Legal
Barry Ticho, Medical Services
Edie Zusman, Mental Health and Addiction
Jennifer Souders, Public Relations and Membership Services

Responsibilities and Purposes

The purposes of the Medical Student Section shall be to encourage and support the active participation of medical students in the ISMS and to provide a representation of student opinions and ideals in organized medicine. In addition, the Medical Student Section shall support the purposes of ISMS as stated in its Constitution. The Medical Student Section is composed of all student members of ISMS.

Illinois State Medical Society Political Action Committee (IMPAC)

The Illinois State Medical Society Political Action Committee will begin its 26th year as a leader in medical politics in 1986. IMPAC is a voluntary non-profit, unincorporated, permanent membership organization. IMPAC serves as the unified political action arm of Illinois physicians and their spouses. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual participation in IMPAC is one means by which the individual physician and his/her spouse can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the Illinois General Assembly and in the U. S. Congress.

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local physician support committees formed on behalf of candidates in U.S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, Twenty North Michigan Avenue, Suite 700, Chicago 60602.

ISMS Resident Physicians Section

Michael Davidson *Chairman*
Richard Quinones, *Vice Chairman*
Richard Terek, *Secretary/Editor*
Rockford G. Yapp, *Delegate*
Mark Ridlen, *Alternate*

Council Representatives

Mike Silver, Economics
John Diveris, Education & Manpower
Bruce Doblin, Governmental Affairs
Richard Quinones, Impaired Physicians Panel
Patrick Stodola, Medical-Legal
Marily Feder, Medical Services
Frank Pieri, Mental Health and Addiction
Mark Ridlen, Pulbic Relations and Membership Services

Responsibilities and Purposes

The purposes of the Resident Physicians Section shall be to encourage and support the active participation of physicians in training in the Illinois State Medical Society and to provide representation of intern-resident opinions and ideas in organized medicine. In addition, the Resident Physicians Section shall support the purposes of the ISMS, as stated in its Constitution. All in-training members of the ISMS shall be members of the Resident Physicians Section, having the right to vote and hold office.

MEDICAL AND ALLIED HEALTH EDUCATION

MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

Chicago College of Osteopathic Medicine
5200 S. Ellis Ave., Chicago 60615
Loyola University, Stritch School of Medicine
2160 S. First Ave., Maywood, 60153
Northwestern University Medical School
303 E. Chicago Ave., Chicago, 60611
Rush Medical College
1725 W. Harrison St., Chicago, 60612
Southern Illinois University School of Medicine
801 N. Rutledge, P.O. Box 3926, Springfield, 62708
University of Chicago-Pritzker School of Medicine
950 E. 59th Street, Chicago, 60637
University of the Health Sciences/The Chicago Medical School
3333 Green Bay Road, North Chicago, 60064
University of Illinois College of Medicine*
Chicago Campus
1853 W. Polk Street, Chicago, 60612

*Note: This is the parent college for Abraham Lincoln School of Medicine, Peoria School of Medicine, Rockford School of Medicine and the School of Basic Medical Sciences (Urbana).

ALLIED HEALTH EDUCATION PROGRAMS

Accredited by the American Medical Association Committee on Allied Health Education and Accreditation

Cytotechnologist

CHICAGO—Michael Reese Hospital & Medical Center
University of Chicago—Lying-in-Hospital

Diagnostic Medical Sonographer

OAK LAWN—Christ Hospital

Electroencephalographic Technologist

SPRINGFIELD—St. John's Hospital

Emergency Medical Tech-Paramedic

JOLIET—Silver Cross Hospital

Histologic Technician

CHICAGO—Holy Cross Hospital
St. Joseph Hospital
University of Chicago Lying-In Hospital

PEORIA—St. Francis Hospital and Medical Center
Methodist Medical Center of Illinois

SPRINGFIELD—Memorial Medical Center
St. John's Hospital

Medical Assistants

BELLEVILLE—Belleville Area College

CARTHAGE—Robert Morris College

PALATINE—William Rainey Harper College

RIVER GROVE—Triton College

Medical Laboratory Technician

BELLEVILLE—Belleville Area College

CHICAGO—Malcolm X College

DES PLAINES—Oakton Community College

DIXON—Sauk Valley College

EAST PEORIA—Illinois Central College

GODFREY—Lewis & Clark Community College

GRAYSLAKE—College of Lake County

KANKAKEE—Kankakee Community College

PALOS HILLS—Moraine Valley Community College

QUINCY—Blessing Hospital

RIVER GROVE—Triton College

Medical Record Administrators

CHICAGO—Chicago State University
University of Illinois at Chicago

NORMAL—Illinois State University

Medical Record Technician

BELLEVILLE—Belleville Area College

CHICAGO—Truman College

DES PLAINES—Oakton Community College

GLEN ELLYN—College of DuPage

GRAYSLAKE—College of Lake County

PALOS HILLS—Moraine Valley Community College

Medical Technologist

BELLEVILLE—St. Elizabeth Hospital

BLUE ISLAND—St. Francis Hospital

CHAMPAIGN—Burnham City Hospital

CHICAGO—Holy Cross Hospital
Illinois Masonic Medical Center
Louis A. Weiss Memorial Hospital
Michael Reese Hospital & Medical Center
Rush-Presbyterian-St. Luke's Medical Center
St. Joseph Hospital
St. Mary of Nazareth Hospital Center
University of Illinois at Chicago Hospital

DANVILLE—Lakeview Medical Center

DECATUR—Decatur Memorial Hospital
St. Mary's Hospital

EVANSTON—Evanston Hospital

FREEPORT—Freeport Memorial Hospital

HINES—Edward Hines Jr. V.A. Hospital

HINSDALE—Hinsdale Sanitarium & Hospital

JOLIET—St. Joseph Hospital

MAYWOOD—Foster G. McGaw Hosp./Loyola University

NORTH CHICAGO—University of Health Sciences/Chicago Medical School

OAK LAWN—Christ Hospital

OAK PARK—West Suburban Hospital Association

UNIVERSITY PARK—Governors State University

PARK RIDGE—Lutheran General Hospital

PEORIA—Methodist Medical Center of Central Illinois
St. Francis Hospital and Medical Center

QUINCY—St. Mary's Hospital

ROCKFORD—Rockford Memorial Hospital
St. Anthony Hospital and Medical Center
SwedishAmerican Hospital

ROCK ISLAND—Augustana College/ Quad City Hospital

SPRINGFIELD—St. John's Hospital
Sangamon State University

URBANA—Carle Foundation Hospital

WAUKEGAN—St. Therese Hospital

Nuclear Medicine Technologist

CHICAGO—Illinois Masonic Medical Center
Northwestern Memorial Hospital

GLEN ELLYN—College of DuPage

HINES—Edward Hines Jr. VA Hospital

OAK LAWN—Christ Hospital

PEORIA—St. Francis Hospital-Medical Center

RIVER GROVE—Triton College

Occupational Therapist

CHICAGO—Chicago State University
University of Illinois at Chicago Hospital

Perfusionist

CHICAGO—Mt. Sinai Hospital Medical Center

Radiation Therapy Technologist

CHICAGO—Chicago State University
Michael Reese Hospital/City Wide College

ELGIN—St. Joseph Hospital

EVANSTON—National College of Education

HINES—Edward Hines Jr. VA Hospital

ROCKFORD—SwedishAmerican Hospital

Radiographer

ARLINGTON HTS.—Northwest Community Hospital

BELLEVILLE—Belleville Area College

CARBONDALE—Southern Illinois University

CENTRALIA—Kaskaskia Junior College

CHAMPAIGN—Parkland College

CHICAGO—Cook County Hospital
DePaul University
Henrotin Hospital
Malcolm X College
Ravenswood Hospital Medical Center
St. Joseph Hospital
South Chicago Community Hospital
University of Illinois at Chicago Hospital
Wilbur Wright College

DANVILLE—Lake View Medical Center

DECATUR—Decatur Memorial Hospital

DES PLAINES—Oakton Community College

DIXON—Sauk Valley College

EAST PEORIA—Illinois Central College

ELGIN—St. Joseph Hospital

EVANSTON—St. Francis Hospital

GALESBURG—Carl Sandburg College

GLEN ELLYN—College of DuPage

GRAYSLAKE—College of Lake County

HINSDALE—Hinsdale Sanitarium & Hospital

KANKAKEE—Kankakee Community College

MACOMB—McDonough District Hospital

MALTA—Kishwaukee College

MOLINE—Black Hawk College/Lutheran Hospital
Moline Public Hospital

NORMAL—Brokaw Hospital

OLNEY—Richland Memorial Hospital

PALOS HILLS—Moraine Valley Community College

PEORIA—St. Francis Hospital Med. Center

QUINCY—Blessing Hospital
St. Mary's Hospital

RIVER GROVE—Triton College

ROCKFORD—Rockford Memorial Hospital
SwedishAmerican Hospital

ROCK ISLAND—Franciscan Medical Center

SOUTH HOLLAND—Thornton Community College

SPRINGFIELD—Lincoln Land Community College
Memorial Medical Center

Respiratory Therapist

CARBONDALE—Southern Illinois University

CHAMPAIGN—Parkland College

CHICAGO—Malcolm X College
Northwestern University
University of Chicago Lying-in Hospital

MOLINE—Black Hawk College/Lutheran Hospital

PALOS HILLS—Moraine Valley Community College

RIVER GROVE—Triton College

ROCKFORD—Rock Valley College

SPRINGFIELD—Lincoln Land Community College

Respiratory Therapy Technician

BELLEVILLE—Belleville Area Jr. College

CHICAGO—Illinois Masonic Medical Center
Marion Adult Ed. Career Trng. Ctr., Inc.
South Chicago Community Hospital

GLEN ELLYN—College of Dupage

KANKAKEE—Kankakee Community College

MOLINE—Black Hawk College/Lutheran Hospital

PALOS HILLS—Moraine Valley Community College

ROCKFORD—Rock Valley College

SPRINGFIELD—St. John's Hospital

WAUKEGAN—Victory Memorial Hospital

Specialist in Blood Bank Technology

CHICAGO—Michael Reese Hospital and Medical Center
Mid-Amer RC Blood Srvs/C.
Hymen Blood Center
University of Illinois at Chicago Hospital

PARK RIDGE—Lutheran General Hospital

Surgical Technologist

CENTRALIA—Kaskaskia Junior College

CHAMPAIGN—Parkland College

EAST PEORIA—Illinois Central College

MOLINE—Moline Public Hospital

QUINCY—Blessing Hospital

RIVER GROVE—Triton College

ROCKFORD—SwedishAmerican Hospital

ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

Election of senators and representatives is determined in the apportioned districts throughout the state. One senator is elected from each of the 59 districts. Each Senate district contains two House districts. Members of the House of Representatives are elected from these 118 single member House districts.

The General Assembly convenes each year on the second Wednesday of January. The General Assembly is a continuous body during the two year term for which members of the House of Representatives are elected. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States Constitution, and act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the President of the Senate. To facilitate the handling of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. The committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.

EXECUTIVE BRANCH

The Constitution provides that the Executive Branch shall consist of the Governor, Lieutenant Governor, Secretary of State, Comptroller, Treasurer, and Attorney General. These elected officers of the Executive Branch shall hold office for four years, beginning on the second Monday of January after their election and, except in the case of the Lieutenant Governor, until their successors are qualified. They are elected every four years.

STATE OFFICERS 1985

Governor, James R. Thompson, Rep., Chicago
Lieutenant Governor, George H. Ryan, Rep., Kankakee
Secretary of State, Jim Edgar, Rep., Charleston
Comptroller, Roland W. Burris, Dem., Chicago
Treasurer, James H. Donnewald, Dem., Breese
Attorney General, Neil F. Hartigan, Dem., Chicago

LEGISLATIVE BRANCH

Legislative Procedure

Each member of the General Assembly has the power to introduce bills or resolutions. When a bill is introduced it is read at large a first time, ordered printed, and referred to the proper committee for consideration, except that in case of an emergency, a bill may be advanced without reference to committee. If the committee recommends the bill favorably, it is sent to second reading, when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading, after which it is acted upon by the entire membership of the house that is considering it.

Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (60 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference committees may be appointed to work out the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the governor for his consideration.

If the governor thinks the bill should become a law, he will sign it. If the governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Three-fifths of the members elected to each house can override the veto. He can also veto specific items of an appropriation bill and he may reduce an appropriation. The governor may also return a bill to the legislature with specific recommendations for change, thereby obviating the need of vetoing the entire bill.

Note

A Legislative Directory containing the names and addresses of all members of the Illinois General Assembly and the Illinois Senators and Representatives in the Congress is available at no cost to ISMS members. Requests should be directed to: Illinois State Medical Society, Regional Office, 701 S. Second St., Springfield 62704.

Department of Alcoholism and Substance Abuse

State of Illinois Center, 100 West Randolph Street, Suite 5-600, Chicago, Illinois 60601.
300 W. Monroe Street, Suite A, Springfield 62706.
Edward T. Duffy, Director

The Illinois Department of Alcoholism and Substance Abuse is the state agency responsible for the public administration and funding of alcoholism and other drug abuse education, treatment, rehabilitation and prevention programs. The Department is responsible for administration of the Illinois triplicate prescription program for designated product controlled substances, scheduling of controlled substances, licensure for drug abuse programs and controlled substances research, training, and administration of initiatives for special populations and a wide variety of demonstration projects. The Department maintains administrative offices in Springfield and Chicago, and regional offices in Springfield, Chicago, Rockford and Mt. Vernon.

Administrative Staff

Daniel W. Behnke, Deputy Director
Roalda J. Alderman, Associate Director for Policy Development and Implementation
Ronald Nelson, Chief Counsel
Linda Hargnett, Special Assistant to the Director
Louis S. DiFonso, Public Affairs Liaison
Roger Mills, Associate Director for Government Relations
James B. Bixler, Administrator, Division of Technology Transfer
Ruth K. Holl, Administrator, Division of Prevention and Education
Felix R. Matlock, Administrator, Division of Management and Budget
Robert Stachura, Administrator, Division of Support Services
John Woodruff, Administrator, Division of Information Services
William Atkins, Administrator, Division of Field Services

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Ted Sanders, Superintendent, Illinois State Board of Education
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Michael Belletire, Director, Illinois Department of Mental Health and Developmental Disabilities
Bernard Turnock, M.D., Director, Illinois Department of Public Health
Susan S. Suter, Director, Illinois Department of Rehabilitation Services
Hon. Jim Edgar, Illinois Secretary of State
Gregory Baise, Secretary, Illinois Department of Transportation
Gregory L. Coler, Director, Illinois Department of Public Aid
Gordon Johnson, Director, Illinois Department of Children and Family Services
Gary L. Clayton, Director, Illinois Department of Registration and Education

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Judy H. Fried, *Vice Chairperson*
Northern Illinois Council on Alcoholism
Russell J. Hagen, Vice Chairman
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Ronald C. Dozier
McLean County State's Attorney
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Mental Health Law Division
Robert Holder
Representative of Building Trades
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Northwestern University Medical School
Hon. John Matijevich
Illinois State Representative
Hon. George E. Sangmeister
Illinois State Senate
Hon. Jill Zwick
Illinois State Representative
Hon. Frank Watson
Illinois State Senate
Kenneth Robbins
Illinois State Hospital Association
Robert C. Hamilton, M.D.
Illinois State Medical Society
Michael Stroden
Assoc. of Labor-Management Administrators & Consultants on Alcoholism
Antonio Garcia
Hispano Alcoholism Services
David Bingaman
Northwestern House
Rev. Donald M. Hallberg
Lutheran Social Services
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Circuit Court of Cook County
Sheriff Richard Doria
DuPage County Court House
Sister Patricia Kilbane
Central States Institute of Addiction
Hon. Terry Steczo
Illinois State Representative
Hon. Dawn Clark Netsch
Illinois State Senate
Hon. Loleta Didrickson
Illinois State Representative
Hon. Forest D. Etheredge
Illinois State Senate
Marian Fiske, Designee
Illinois Nurses Association
Dean Sweet
Sangamon-Menard Alcoholism and Drugs Council
Jack Arkins
Illinois Pharmacists Association
Judith Munson
DuPage County Health Department
Eldoris Mason
Brass Foundation, Inc.
Larry Wilms
Prairie Center
Peter Bokos, Ph.D.
Interventions, Inc.

Department of Children and Family Services

100 W. Randolph, Sixth Floor, Chicago 60601
One North Old State Capitol Plaza, Springfield 62706
Gordon Johnson, Director

The Illinois Department of Children and Family Services is the state agency responsible for providing child welfare and child protection services to children and their families. The current caseload is 39,500 children and families. Services provided by the Department, either directly or through purchase from private agencies, include counseling; the care of children in foster homes, group homes, and institutions, adoption, day care; help to unwed parents, and the licensing and monitoring of some 20,000 child care facilities. The Department also contracts with individuals as advocates and homemakers to work with children and par-

ents on a one-to-one basis.

The Department has three main divisions responsible for delivering services. The Division of Child Protection is responsible for investigating reports of suspected child abuse and neglect. In fiscal year 1985, nearly 70,000 children were reported as suspected abuse or neglect victims.

The Division of Youth and Community Services specializes in services for adolescents. It is responsible for a grant-in-aid program of community-based services to troubled youth, juvenile justice and delinquency prevention programs, a multi-agency program for emotionally disturbed youngsters, and a variety of youth employment programs. Through the Department's eight service regions, the Division of Program Operations administers the agency's various service programs for abused, neglected, and dependent children and their families.

Director's Office

Paul Freedlund, Executive Deputy Director
Michael Horstman, Special Assistant to the Director
Janis Forte, Special Assistant to the Director
Thomas E. Villiger, Deputy Director, Division of Child Protection
Constance Mercer, Deputy Director, Division of Policy and Plans
John J. Robinson, Deputy Director, Division of Program Operations
Bruce Rubenstein, Deputy Director, Division of Youth and Community Services
David King, Deputy Director, Division of Management and Budget
Donald H. Schlosser, Chief, Office of Communication/Community Relations
Mauriece Graham, Chief, Office of Internal Audits
Michael C. Prinzi, Chief Counsel, Office of Legal Services
Jan van Blommesteyn, Chief, Office of Personnel and Labor Relations
William G. Hall, Legislative Liaison
Robert T. Blackwell, Chief, Office of Program Review
Linda Avery, Chief, Office of Inter-Agency Coordination
James Stricker, Chief, Office of Investigation

Regional Offices

Thomas Brinton, Region 1A Administrator, Rockford
Thomas Ward, Region 1B Administrator, Peoria
Jack Zentz, Region 2A Administrator, Aurora
Roland Kulla, Region 2B Administrator, Chicago
William Gillespie, Region 3A Administrator, Springfield
Willis Hartman, Region 3B Administrator, Champaign
Anthony Jenkins, Region 4 Administrator, East St. Louis
Gene Ruehmkorff, Region 5 Administrator, Marion

Advisory Councils

DCFS Advisory Council, Karyl Thorsen, Chairperson
Statewide Citizen's Committee on Child Abuse and Neglect, Joseph P. Mayo, Chairperson
State Advisory Committee on Day Care, Laurel Walker, Chairperson
Illinois Juvenile Justice Commission, Dallas C. Ingemunson, Chairperson
Statewide Foster Care Advisory Committee, Emil Stahlhut, Chairperson

In addition to the above, each of the eight regions has its own advisory committee and various youth planning committees.

Department of Corrections

100 West Randolph, 4th Floor, Chicago, IL 60601.
P.O. Box 4902, 1301 Concordia Court, Springfield, IL 62708-4902.
Michael P. Lane, Director

Leo L. Meyer, Deputy Director-Adult Division
James R. Irving, Deputy Director-Juvenile Division
Douglas A. Brown, Deputy Director-Community Services Division
J. Thomas Hutchison, Deputy Director-Bureau of Administration and Planning
William H. Craine, Ph.D., Deputy Director-Bureau of Employee and Inmate Services
Robert H. Klemm, Deputy Director-Bureau of Inspections and Audits
Samuel J. Sublett, Accreditation Manager
Nick Howell, Chief Public Information Officer
Richard G. Brown, Chief of Intergovernmental Relations
Dr. Ronald Shansky, Medical Director

Programs: 1) To develop and maintain reception and evaluation units for the purpose of analyzing the security, physical and mental needs of juvenile and adult offenders committed to it and to assign such persons to institutions and programs under its control or transfer them to other appropriate agencies; 2) to develop and maintain programs of control, adjustment and employment of committed persons within its institutions; 3) to establish a system of release, supervision and guidance of committed persons in the community; 4) to maintain records of persons committed to it and to establish programs of research, statistics and planning; 5) to investigate the grievances of any person committed to the agency and to inquire into any alleged misconduct by employees; and 6) to cooperate with other departments and agencies and with local communities for the development of standards and programs for better correctional services within the State.

Department of Mental Health and Developmental Disabilities

401 S. Spring St., Springfield, 62706
State of Illinois Center, 100 West Randolph, Suite 6-400, Chicago, 60601
Michael A. Belletire, Director

Paul Schyve, M.D., Chief of Clinical Services
Ugo Formigoni, M.D., Associate Director for Mental Illness
William K. Murphy, Associate Director for Developmental Disabilities
Terry Brelje, Ph.D., Associate Director for Policy and Special Programs

Office of the Director

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Russell Blaauw, Legislative Liaison
Douglas Carey, Public Relations
David B. Thomas, Chief Auditor
Dorothy Ackman, Administrative Assistant
Harriett Mitchell, Administrative Assistant

Director's Executive Council Members and Regional Administrators

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William K. Murphy, Associate Director for Developmental Disabilities
Ugo Formigoni, M.D., Associate Director for Mental Illness
Terry Brelje, Ph.D., Associate Director for Policy and Special Programs

Kenley Wade, Acting Director, Illinois Institute for Analysis, Research and Technology Transfer
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Edwin Goldman, Region 2 Administrator, Elgin
Charles Harris, Ph.D., Acting, Region 3 Administrator, Springfield
Ronald G. Bittle, Ph.D., Region 4 Administrator, Anna
Donna Johnson, Coordinator, Region 5A & 5B, Chicago
Patricia Barger, Ph.D., Region 5A (North) Administrator, Chicago
Ruth Williams, Region 5B (South) Administrator, Chicago
James Grot, Ph.D., Region 6 Administrator, Tinley Park

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Michael Taylor, M.D., North Chicago

Department of Public Aid

316 South 2nd St., Springfield, 62762
624 S. Michigan Ave., Chicago 60605
Gregory L. Coler, Director

The Illinois Department of Public Aid assists over one million Illinois residents experiencing financial or medical hardships. The Department administers the following programs: Aid to Families with Dependent Children, Medical Assistance, and Aid to the Aged, Blind, or Disabled. The Department also allocates state funds to qualified and requesting governmental units for the administration of General Assistance; and in cooperation with the U.S. Department of Agriculture, administers the Food Stamp Program. The Child Support Enforcement Program is a joint effort of the Department, the Attorney General, and local state's attorneys to obtain court-ordered child support from parents. Support enforcement services are provided to any family who needs help collecting child support. The Department recently created the Office for Hospital Services in the Medical Programs Division. This office administers the Illinois Competitive Access and Reimbursement Equity Program (ICARE), which assures access to quality hospital care for recipients and promotes competition among hospitals for the purchase of their services. Among other initiatives within the Medical Programs Division are nursing home reform and prepaid health programs.

Administrative Staff

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Department of Public Health

535 West Jefferson St., Springfield 62761
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Dorothy H. Hubler, R.Ph., M.D., Casey
Edward G. Nicholson, R.Ph., D.O., Chicago

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Elizabeth H. Fung, M.S.W., Chicago
Naidene Kirwan, Oak Lawn
John E. Nathan, D.D.S., M.S.D., Chicago
William Rushakoff, Chicago
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Toni Perrin, East St. Louis
John Huther, Ph.D., *ex-officio,* IBHE

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Albert Bucar, O.D., Antioch
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Alternates:
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Alternate:
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Allen Hatfield, M.D., Urbana
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(Allied with Public Health Operations)

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Department of Registration and Education

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Shari Dam, Chief of Prosecutions
Tom Killala, Chief of Medical Investigations
Russ Friedewald,
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The Department is primarily concerned with the registration, licensing and enforcement of 30 laws governing the different professions, trades and occupations, including the Medical Practice Act.

The Medical Examining Committee, appointed by the director of the Department, operates within the framework of the Act and is charged with the responsibility of supervising examinations for licensure and making recommendations to the Director to grant or refuse to grant licenses. The Medical Disciplinary Board, appointed by the Governor, reviews alleged violations of the Medical Practice Act, hears complaints for revocation and suspension of licenses and recommends disciplinary action to the Director.

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MEDICAL PRACTICE ACT

Due to its lengthy nature, *IMJ* is unable to publish the complete text of the Medical Practice Act. However, because of its importance to the practicing physician, physicians are encouraged to obtain a copy of the Act from the Department of Registration and Education, 320 W. Washington Street, Springfield, IL 62786.

Several changes to the Medical Practice Act were made this year by the General Assembly, and have been signed by the Governor. Very briefly, changes were made during the past year to:

- Allow the Medical Disciplinary Board to order mental and physical examinations for those licensed under the Act that are accused of violating the Act.
- Require the Department of Registration and Education, upon recommendation of the Medical Practice Examining Committee, to promulgate continuing education requirements for persons licensed under the Medical Practice Act who are not otherwise subject to continuing education requirements of their specialties, societies or boards.
- Permit the use of the designation "Doctor of Medicine" or "M.D." by a person licensed to practice medicine in all its branches who has received a degree in medicine from other than an osteopathic medical college notwithstanding that such degree does not literally translate into "Doctor of Medicine" or "M.D.".

IMJ will continue to publish this annual summary of revisions to the Medical Practice Act as they are affected by the Illinois General Assembly and signed by the Governor.

Department of Rehabilitation Services

623 East Adams Street
Springfield, IL 62706
Susan S. Suter, Acting Director

The Department of Rehabilitation Services (DORS) is the state's leading agency helping disabled children, youth, and adults reach their full potential and their goals for a productive, independent life. Funded by state and federal funds, DORS provides a variety of rehabilitation services to eligible persons, including children and youth who cannot be adequately served by their local public schools; adults of or near working age who have diagnosable physical and/or mental disabilities which interfere with their ability to get or keep jobs; and severely disabled adults under age 60 who are at risk of institutionalization but who could remain at home if certain, specific services were provided.

DORS assists clients in selecting the needed services; serves as a link to service groups, rehabilitation facilities and other governmental agencies; and makes medical eligibility determinations for persons applying for benefits under the Social Security Disability Insurance and Supplemental Security Income programs.

DORS offers its services through a number of program components, including the Vocational Rehabilitation Program, the Home Services Program, the Illinois Visually Handicapped Institute, Community/Field Services for the Visually Handicapped, the Illinois School for the Deaf, the Illinois Children's School and Rehabilitation Center, the Illinois School for the Visually Impaired, the Secondary Work Experience Program and the Vending Stand Program.

Illinois Health Care Cost Containment Council

516 E. Monroe St., Suite 200, Springfield 62701
James S. Tripp, Executive Director

In August, 1984, Illinois Governor James R. Thompson signed into law Senate Bill 495, which created a new body reporting directly to the Illinois General Assembly independent of any specific code department. That body, the Illinois Health Care Cost Containment Council, was appointed to fulfill the legislative mandate to hold down the cost of health care in Illinois. It was instructed to establish a data system which will collect bills for all hospital discharges, to prepare quarterly public reports on health care charge and utilization trends and to recommend additional methods to restrain the rise in health care costs. Three health care providers, three consumers, two insurers and three representatives of the business community were appointed. Recommendations are to be forwarded to the General Assembly no later than March, 1986.

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The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in the reference section. Members who wish to notify the Chairman of the Board of their availability can clip and submit the coupon below.

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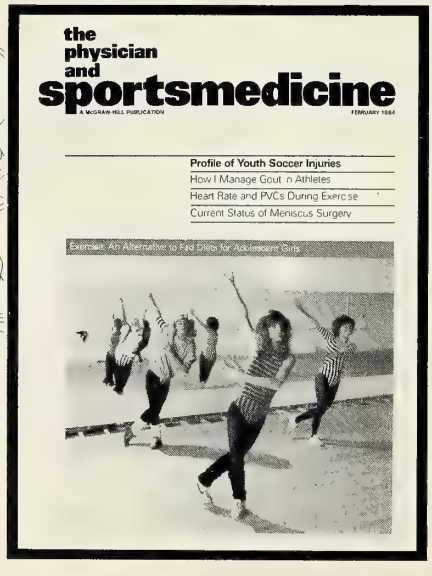
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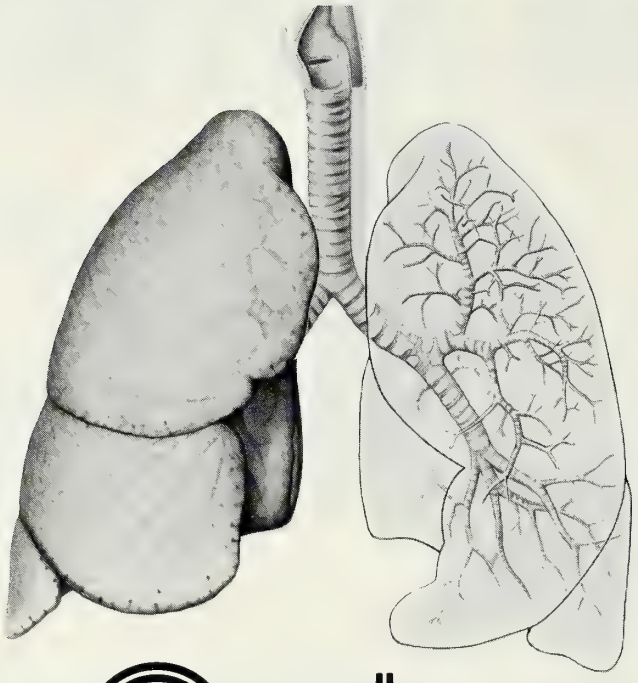
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Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Ceclor (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile* Other causes of colitis should be ruled out

Precautions: *General Precautions* — If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy — *Pregnancy Category B* — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor® (cefaclor, Lilly) have been detected in mother's milk following administration of single 500-mg doses Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known Caution should be exercised when Ceclor is administered to a nursing woman

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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EKG

(Continued from page 201)

Answers: 1. C. D. E. 2. A. D. E.

This arrhythmia is a multifocal atrial tachycardia. The diagnosis is made on the ECG when the rate is greater than 100 beats per minute and there are at least three different P wave morphologies with varying PR and RR intervals. Virtually all P waves are conducted occasionally with aberrant intraventricular conduction as the second conducted P wave in leads AVR, AVL, AVF. P waves are best seen in leads II and V_1. The last beat in lead V_1 and the first two beats in lead V_4 are ventricular in origin. The QS pattern in leads V_1 and V_2 are compatible with the history of old myocardial infarction. Multifocal atrial tachycardia is uncommon. It is difficult to treat because it is often related to the underlying disease process, often chronic pulmonary disease. Although digoxin and quinidine may be helpful, treatment efforts are usually directed toward the underlying disease process. More recently, verapamil was found useful.[1] The disease process here was severe chronic obstructive pulmonary disease.

All of the possibilities in question 2 are reasonable but bronchoscopy could be delayed and endotracheal intubation was not yet needed. The chest x-ray showed a right middle lobe infiltrate, emphysematous changes, pulmonary vascular redistribution, and peribronchial thickening. A hemoglobin was 19.0gms%. Admitting arterial blood gas analysis showed a pH 7.40, pO_2 59mmHg, and a pCO_2 46mmHg. After oxygen was administered by nasal cannula at two liters flow, repeat arterial blood gases were pH 7.32, pO_2 56mmHg, and pCO_2 49mmHg. The differential diagnosis of our patient's bronchial apoplexy included acute bronchitis, congestive heart failure, pulmonary embolism, and endobronchial tumor. His medications included long-acting theophylline 300mg TID, prednisone 20mg/day, digoxin 0.125mg/day, furosemide 80mg/day, albuterol qid, and potassium chloride. Antibiotics were started but the patient's distress worsened to respiratory failure. Endotrachial intubation was required. Transient hypotension developed and pulmonary embolism was strongly suspected. The patient was too unstable for more invasive procedures so heparin anticoagulation was begun. The hemoptysis stopped and the patient's pulmonary function returned to its baseline. Phlebotomy, chronic anticoagulation, and a dose reduction of theophylline were added to the treatment plan. The cardiac rhythm converted to atrial fibrillation with a controlled ventricular rate. Despite these maximal medical measures, the patient died of respiratory failure four months after this admission.

References

1. Leving, J.H., Michael, J.R., Guarnieri, T. "Treatment of Multifocal Atrial Tachycardia with Verapamil," *NEJM* 312:21, 1985.

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In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

ALTON:
Population 38,000. Opening a new multimodality diagnostic and treatment center in December, 1985. State-of-the-art equipment includes magnetic resonance, computed tomography, linear accelerator, extensive cardiac studies equipment, chemotherapy facilities, as well as several suites available for private practice physicians. We also plan to have a walk-in outpatient clinic, outpatient surgical center, and pharmacy within the clinic. We are especially interested in physicians practicing in neurology, internal medicine, oncology, orthopedics, pediatrics, cardiology, pathology, urology, gastroenterology, radiation therapy, general surgery, OB/GYN surgery, family practice, and neurosurgery. Available immediately. Contact: Bruce Vest, M.D. or Kimberly Eizember, Doctors Clinic, P.O. Box 617, Alton 62002, (618) 474-7850. (1)

BLOOMINGTON:
Internal Medicine—To join an active six member IM practice in mid-western university community. A sub-specialty in rheumatology, endocrinology, or allergy is desirable, but not necessary. Contact: J. Buchanan, The Health Center, 702 N. East St., Bloomington 61701 (309) 827-5051. (9)

CARBONDALE:
Multi-specialty group needs the following physicians—allergist, pulmonologist, otolaryngologist and orthopedist. Contact: Wayne Given, 2601 West Main Street, Carbondale 62901, (618) 549-5361. (12)

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GRAYVILLE:
On Interstate 64; Population 3,000; 65,000 medical market area. Modern, completely furnished medical-dental clinic facility, 20-minutes from two modern hospitals. Steady economy—oil, light manufacturing, coal mining, power generating, agriculture and service industries. Contact: C.W. Wilson, 610 North Court Street, Grayville 62844, (618) 375-6341. (1)

LINCOLN:
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MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

The clinical features in 68 cases of confirmed spinal stenosis were studied over a 30 month period. Pseudoclaudication was noted in 94%, expressed as pain in 93%, numbness in 63%, or weakness in 43%. Symptoms were bilateral in 68% of cases and relieved by trunk flexion. Neurologic findings were mild and infrequent. The electromyographic data on 37 cases showed one or more lumbosarcal radiculopathies in 34 cases. All patients showed narrowing on myelography, most commonly at levels L2, 3 and L4. On average of four years post-operatively, 84% reported good to excellent results. (Hall, S., *et al: Ann Int Med* 103#2:271-5, 1985)

Diagnostic screening tests were evaluated as to efficacy and usefulness in the treatment regimen on patients between 74-97 years of age and within a nursing home. Within a four year period, the investigators reviewed routine admission screening laboratory data performed on 70 of these patients and noted only two instances where a change in management resulted. One of these was a bacteruria not treated; another was hypercholesterolemia where a dietary modification was instituted. Admission screening revealed an incidence of abnormality in 20%. Annual screening in 2,602 tests revealed 447 abnormalities with only two instances eliciting management changes-one case of asymptomatic bacteruria, and one case of positive stool guaiac secondary to Zenker's diverticulum not treated surgically or symptomatically. The authors question the value and expense of performing many of these repeat screening tests. (Domoto, K. *et al: Am J Pub Health,* 75:243-245, 1985)

The mothers of newborns were interviewed and some medical charts were evaluated as to the relationship of medications and congenital heart defects. Acetaminophen, ampicillin, tetracycline, anticonvulsants, aspirin, diazepam, codeine, insulin, phenothiazine, and phenylephrine uses were evaluated if used within the first trimester. Aspirin use may predispose to aortic stenosis, coarctation of the aorta, hypoplastic left ventricle, and transposition of the great arteries. Tetracycline may be associated with a greater incidence of transposition of great arteries; ampicillin with a single ventricle; codeine with a double outlet right ventricle; and anticonvulsants with any congenital heart disease. Bendectin was not noted to be significantly associated with congenital cardiac malformations. (Zierler, S., Rothman, K.: *NEJM* 313:347-52, 1985)

Reductions of cholesterol and low-density-lipoprotein/cholesterol ratios were evaluated in three groups of patients who exercised regularly but showed variations in body weight. The best results occured when exercise was associated with weight loss. An increase in body weight was associated with a concomitant increase in cholesterol and low-density-lipoprotein cholesterol levels. (Trans, Z. Weltman, A.: *JAMA* 254:919-924, 1985)

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GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

NOVEMBER

Pediatrics

Intensive Course in Pediatric Nutrition
For: Physicians, interested allied health. Symposium, November 11-15, Iowa City, IA. **Sponsor:** University of Iowa College of Medicine Dept. of Pediatrics, UI Hospitals & Clinics, Iowa City, IA 52242. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: approx. 33 hours. **Contact:** Samuel J. Fomon, M.D. at the above address.

Seminars in Pediatrics
For: Physicians and pediatric nurses. Conference, November 1-2, Madison, WI. **Sponsors:** University of Wisconsin, Madison-CME and Department of Pediatrics, 465 WARF Bldg., 610 Walnut Street, Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 11 hours; AAFP Prescribed: 10.75 hours; AOA Category 2-D; University of Wisconsin CEU's: 11 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Geriatrics

Fourth Annual Symposium on Geriatric Medicine
For: Physicians. Symposium, November 6, Holiday Inn Westport, St. Louis, MO. **Sponsor:** St. Louis University School of Medicine, CME, 1402 South Grand Blvd., St. Louis, MO 63104. **Fee:** $45. **Reg. limit:** None. **Credit:** Category 1: 6 hours. **Contact:** Anita Herbst. **Phone:** (314) 664-9800.

Pathology

Panel on Problem Areas in Cytopathology
For: Pathologists and cytopathologists. Symposium, November 11, 7:00 P.M., Drake Hotel, Chicago, IL. **Sponsors:** Chicago Pathology Society and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall Short, M.D., Dept. of Pathology, Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644.

Otolaryngology

Otolaryngology Head and Neck Workshop
For: Otolarynologists, D.O.'s, D.O.V.'s. Workshop, November 10-12. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $1,000. **Reg Limit:** 15. **Credit:** Category 1: 20 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

OB/GYN

Hysteroscopy Workshop
For: Obstetricians, gynecologists. Workshop, November 15-16, Chicago, IL **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $300. **Reg. Limit:** 200. **Credit:** Category 1: 9 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Surgery

Fiberoptic Esophagogastric Endoscopy
For: Surgeons, internists, gastroenterologists. Lecture with workshop, November 11-13. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $490. **Reg. Limit:** 15. **Credit:** Category 1: 16 hours. **Contact:** Robert J. Baker, M.D. **Phone:** in Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Flexible Fiberoptic Sigmoidoscopy
For: Surgeons and internists. Lecture with workshop, November 16, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $145. **Reg. Limit:** 75. **Credit:** Category 1: 7 hours; AAFP Prescribed: 7 hours **Contact:** Robert J. Baker, M.D. **Phone:** in Illinois: (800) 621-4649; outside Illinois:(800) 621-4651.

Unique Seminars

The "Leadership" seminar assists the medical leadership in understanding the basic elements of effective CME planning. Participants will gain a foundation of skill in group techniques to involve medical staff members in CME planning and in how to start the systematic effort that leads to effective CME in the hospital setting.

The "Evaluation of CME Process" seminar provides the medical leadership with the practical information to apply the purposes of evaluation to program administration, faculty performance and participant learning. The leadership will discuss various common techniques used in the evaluation process for the development and implementation of quality CME programs.

For further information about participating in a unique ICCME seminar, please contact the Illinois State Medical Society, Twenty North Michigan Avenue, Chicago Illinois 60602 (312-782-1654).

Urology/Radiology/Pathology
Urologic Pathology and Radiology
For: Urologists, pathologists and radiologists. Lecture, December 9-13, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Fee:** $615. **Reg. Limit:** 50. **Credit:** Category 1: 41 hrs. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** Local: 633-2600; in Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Cardiology/Family Medicine/Emergency Medicine
5th Annual Conference on Heart Diseases: Imaging Comes to Cardiology
For: Physicians and other health professionals. Conference, December 6-7, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME; Wisconsin Medical School; Wisconsin Hospital and Clinics. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 12 hrs.; AAFP Prescribed: 9½ hrs.; University of Wisconsin CEU's: 12 hrs.; AOA Category 2-D: 9½ hrs. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Gynecology
Problem Solving in Gynecologic Encocrinology and Infertility
For: Gynecologists. Course, December 6-7, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Catgory 1: 10 hours; ACOG: 10 Cognates. **Contact:** Marlene Goldberg. **Phone** (312) 962-1056.

Cardiology
Cardiology Conference
For: Physicians and other medical professionals. Conference, December 6, Springfield, IL. **Sponsor:** Southern Illinois University School of Medicine, Box 3926, Springfield, IL 62708. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 7 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean, CME. **Phone:** (217) 782-7711.

Third International Symposium on Electrophysiologic Basis for Diagnosis and Management of Cardiac Arrhythmias
For: Physicians, cardiac technologists, and nurses. Symposium, December 27-30, Orlando, FL. **Sponsors:** University of Wisconsin-Madison, CME; Mt. Sinai Medical Center, Milwaukee; American Heart Association; Florida Heart Institute, Orlando, FL; and Continuing Research Foundation, Elm Grove, WI. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 19 hours; AAFP **Elective:** 19 hours; AOA Category 2-D, University of Wisconsin CEU's: 19 hours. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Emergency Care
Trauma
For: Physicians, and emergency care professionals. Symposium, December 5, 3:00-7:00 p.m., Quincy, IL. 'Sponsor: Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean for CME. **Phone:** (217) 782-7711.

Emergency Medicine
Advanced Trauma Life Support Provider Course
For: Physicians and emergency care professionals. Course, December 4-5, 8:00 a.m.-5:00 p.m., Springfield, IL. **Sponsor:** Southern Illinois University School of Medicine. **Fee:** $350. **Reg. Limit:** 20. **Credit:** Category 1: 16 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean for CME. **Phone:** (217) 782-7711.

Neurosurgery
Neurosurgery Laser Workshop
For: Neurosurgeons. Workshop, November 18-19, Chicago, IL. **Sponsor:** Northwestern University Medical School, 301 E. Chicago Avenue, Chicago, IL 60611. **Fee:** $900. **Reg. Limit:** 12. **Credit:** Category 1: 19 hours. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

Anesthesiology
Workshop in Fiberoptic Endoscopy
For: Anesthesiologists. Workshop, November 23, Chicago, IL. **Sponsor:** Northwestern University Medical School, 301 East Chicago Avenue, Chicago, IL 60611. **Fee:** $225. **Reg. Limit:** 40. **Credit:** Category 1: 1 hour. **Contact:** Paula Puntenney. **Phone:** (312) 908-8533.

The Illinois Council on Continuing Medical Education offers individual consultations to physicians/educators involved in the development and implementation of CME programs. Please contact the staff of the ICCME for further information: ICCME/ISMS, Division of Medical Education, Twenty N. Michigan Avenue, Suite 700, Chicago, IL 60602 or (312) 782-1654.

Internal Medicine
Advances in Internal Medicine 1985
For: Internists, November 11-15. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $500. **Reg. Limit:** 90. **Credit:** Category 1: 35 hours. **Contact:** Robert J. Baker, M.D. **Phone:** in Illinois: (800) 621-4649; outside Illinois (800) 621-4651.

Dermatology/Laser
Dye Lasers in Dermatology; Laser Medicine and Surgery at Northwestern Memorial Hospital Seminar Series
For: Physicians, medical students, nurses, and related paramedicals. Seminar, November 11, 5-6:30 p.m., Northwestern University Medical School Alumni Center, 303 E. Chicago Avenue, Chicago, IL 60611. **Sponsor:** Northwestern Memorial Hospital Laser Committee. **Fee:** None. **Reg. Limit:** None. **Credit:** None. **Contact:** Elaine Brown. **Phone:** (312) 908-4480.

Allergy
Legal Issues in Health Care
For: Interested physicians. Lecture, November 18, 6:00 p.m. (cocktails); 7:00 (dinner); 8:00 p.m. (lecture) Holiday Inn Chicago City Centre. **Sponsor:** Illinois Society of Allergy & Clinical Immunology. **Fee:** $15.00. **Reg. limit:** None. **Credit:** Category 1: 1 hr. **Contact:** Diane Kubis. **Phone:** (312) 255-1024.

Infectious Diseases
Update in Infectious Diseases 1985
For: Physicians and other health professionals. Conference, November 21-23, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME and School of Medicine. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 19 hrs; AAFP: Credit pending; University of Wisconsin CEU's: 19 hrs. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

DECEMBER

Cardiology/Family Medicine/Internal Medicine
Third International Symposium on Electrophysiologic Basis for Diagnosis and Management of Cardiac Arrhythmias
For: Physicians, cardiac technologists and nurses. Conference, December 27-30, Orlando, FL. **Sponsors:** University of Wisconsin-Madison, CME; Mount Sinai Medical Center, Milwaukee; American Heart Association; Florida Heart Institute and Continuing Education and Research Foundation. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 19 hrs.; AAFP Elective: 19 hrs.; University of Wisconsin CEU's: 19 hrs and AOA Category 2-D. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Pathology
Symposium on Recent Advances in Clinical Microbiology
For: Pathologists and microbiologists. Symposium, December 9, 7:00 p.m., Drake Hotel, Chicago. **Sponsors:** Chicago Pathology Society and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall Short, M.D., Dept. of Pathology, Loretto Hospital, 645 S. Central Avenue, Chicago, IL 60644.

Neurology
Neurology for the Non-Neurologists
For: Family Practitioners, Internists and Psychiatrists. Lectures, workshops, December 4-5, 8:30 a.m.-5:00 p.m. and December 6, 8:30 a.m.-3:30 p.m. **Sponsor:** Rush University and Rush-Presbyterian St. Luke's Medical Center CME, 600 S. Paulina, Chicago, IL 60612. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 20 hours; AAFP Elective: 20 hours. **Contact: Barbara Trejo. Phone:** (312) 942-7095.

Critical Care Medicine
1st Annual Joint Indo-American Critical Care Symposium
For: Doctors, advanced nursing. Lectures, December 21-23 in New Delhi, India. December 28-31 in Hyderabad, India, 8:30 a.m.-5:10 p.m. (both locations). **Sponsors:** The Chicago Medical School/The University of Health Sciences, 3333 Green Bay Road, North Chicago, IL 60064; Ashok Paul Memorial Fund; The All India Institute of Medical Sciences, New Delhi, India; and The Osmania Medical College/Osmania University, Hyberad, India. **Fee:** $250. **Reg. Limit:** None. **Credit:** Category 1: 40 hours. **Contact:** Elizabeth Bruechert. **Phone:** (312) 578-3000, Ext. 604.

Pediatrics
Current Problems in Pediatrics
For: Pediatricians and practitioners dealing with children. Lecture, December 2-6, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Fee:** $540. **Reg. Limit:** 90. **Credit:** Category 1: 40 hrs.; PREP: 40 hrs. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** Local: 633-2600; in Illinois: (800) 622-4649; outside Illinois: (800) 621-4651.

JANUARY

Allergy
Contact Dermatitis and Atopic Eczema
For: Interested physicians. Lecture, January 20 (6:00 p.m. cocktails and dinner; 8:00 p.m. meeting), Chicago. **Sponsor:** The Illinois Society of Allergy and Clinical Immunology, 800 E. Northwest Hwy., Suite 101, Mt. Prospect, IL 60056. **Fee:** $15. **Reg. Limit:** None. **Contact:** Diane Kubis. **Phone:** (312) 255-1024.

Family Practice
Introductory Course to Osteopathy in the Cranial Field
Course, January 7-11, 8:30 a.m.-6:30 p.m., Chicago O'Hare Marriott Hotel, Chicago, IL. **Sponsors:** Chicago College of Osteopathic Medicine and Sutherland Cranial Teaching Foundation. **Fee:** $675. (send fee to: Sutherland Cranial Teaching Foundation, 1140 W. 8th St., Meridian, Idaho 53642) **Reg. Limit:** 44. **Contact:** Richard A. Feely, D.O. **Phone:** (312) 266-8565.

Pathology
Joint Meeting with American Association of Clinical Chemists
For: Pathologists and clinical chemists. Symposium, January 13, 7:00 p.m., Drake Hotel, Chicago. **Sponsors:** Chicago Pathology Society and Michael Reese Hospital. **Fee:** None. **Contact:** Marshall Short, M.D., Dept. of Pathology, Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644.

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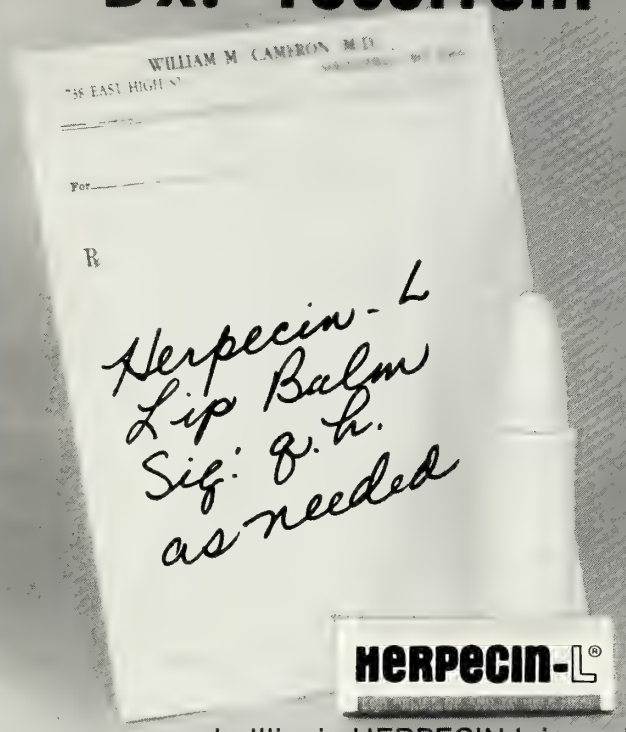
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Liability Crisis Widespread

Let's Not Lose the Initiative



The liability crisis is becoming pandemic. Not only physicians and hospitals, but also other segments of society, are feeling the crunch. Product liability claims against manufacturers, and personal injury claims against municipalities, day care centers, school boards, and park districts, are adding to the pressure. Outlandish premiums, lack of reinsurance, availability of only claims-made insurance and even uninsurability are becoming commonplace.

The unreasonably high judge and jury awards, now routine in all of these areas, are jeopardizing many segments of the insurance industry itself. The medical profession has been the leading edge of a disastrous trend now encompassing society at large. Both the insurance-related trade media and the lay media are stepping up their reporting of this alarming trend. The volatile malpractice insurance market was examined at length in *Best's Review* (September, 1985) while *Forbes* (July 15, 1985) has raised the spectre of "A World Without Insurance." Meanwhile the *Chicago Sun-Times* (June 17, 1985) has catalogued how legal penalties are "overwhelming" our cities.

The general trend presents us, as physicians, with a great opportunity to become leaders in our communities by speaking out and forming coalitions with business leaders, accountants, engineers, and others to make significant changes in the whole tort system. We all need caps on the multi-million dollar non-economic awards strangling our insurance system.

We can lead by following up on our May 22nd success in Springfield. Keep your action teams going in anticipation of the 1987 General Assembly session when we will again seek caps on non-economic awards. And if your colleagues need motivation in this regard, tell them about the 1,189 suits filed in Cook County in the two weeks prior to August 15th—the effective date of the new malpractice law. Tell them that there were 47 suits filed in the two days before that date in DuPage County—an area with an average monthly filing of only three. Tell them that some of these suits were filed as "John Doe" suits with no actual defendants named. Ask their help as you work to spread this word through newspapers, radio and TV stations, service clubs, and church groups. Let's not lose the initiative. ◀

Morgan M. Meyer

Morgan M. Meyer, M.D.
ISMS President

ABSTRACTS OF ACTIONS

September 28, 1985 *ISMS Conference Complex*

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

BLUE CROSS/BLUE SHIELD MEDICAL NECESSITY RIDER

Recently Blue Cross/Blue Shield developed and distributed a Medical Necessity Rider, which is being affixed to group insurance policies at the request of the insured. This rider excludes payment for "hospitalization, services and supplies whch are not, in the judgment of Blue Cross/Blue Shield, medically necessary." Medical necessity means that a specific medical, health care hospital service is required, in the reasonable judgment of Blue Cross/Blue Shield, for the treatment or management of a medical symptom or condition, and that the service or care provided is the most efficient and economical care or service which can safely be provided.

The Board agreed to: (A) Inform the membership of the recent Blue Cross/Blue Shield Medical Necessity Rider attached to group insurance policies, asking members to report complaints or questions; (B) Nominate interested physicians to become involved in the review process; (C) Authorize a review committee to oversee this matter; and (D) Direct further discussion with BC/BS in order to propose more acceptable Medical Necessity Rider language.

PLI COURT CHALLENGE

Immediately following Governor Thompson's signing the malpractice reform legislation, a lawsuit was filed in the Chancery Division of the Cook County Circuit Court. This is a unique approach through a "Taxpayer's Suit" asking the court to enjoin any state officials from expending any tax monies to publish or in any way pay any warrants caused by implementation of this law.

The Board authorized the filing of an amicus curiae in the case of *Bernier v. Roland Burris, et. al.,* which challenged the constitutionality of the tort reform legislation.

PLI PRE-TRIAL SCREENING PANELS

Several circuit court chief judges, including Judge Comerford of Cook County, have approached ISMS for assistance in finding physicians to participate in pre-trial screening panels. The Board authorized the distribution of solicitation letters to all members asking for participation on Pre-Trial Screening Panels.

PLI LOCALITY RULE

In a recent malpractice case, the plaintiff expert witness based his opinion on the national standard of care. On motion of the defendant, this testimony was struck as it did not reflect the community standard. The ruling of the Circuit Court was affirmed by the Fourth Appellate Court.

Subsequently, plaintiff has appealed this to the Illinois Supreme Court and leave has been granted. Should the ruling be overturned, it would allow a national standard to be applied in all medical malpractice cases, rather than the community standard. The Executive Committee reviewed this and agreed that ISMS should ask to intervene with the Supreme Court through an amicus brief in support of maintaining the community standard rule.

The Board ratified authorization of an amicus before the Illinois Supreme Court in a recent malpractice case challenging the locality rule.

PHYSICIAN LIABILITY UNDER PRO

As a result of an IHA memo, some physicians are being advised that under a provision of TEFRA, they may be immune from professional liability actions when providing medical care if they complied with or relied upon PRO norms, as long as due care was exercised.

The Board approved the publication of a notice in an appropriate ISMS periodical, advising that the portion of TEFRA advising that physicians may be immune from professional liability actions when providing medical care if they complied with or relied upon PRO norms as long as due care was exercised, does not provide meaningful immunity to professional liablity litigation.

(Continued on page 348)



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WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.
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Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in triplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

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THE VIEWBOX

CONTRIBUTING EDITOR TERRENCE C. DEMOS, M.D., PROFESSOR OF RADIOLOGY, DEPARTMENT OF RADIOLOGY, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE

This month's Viewbox was contributed by Clare Tempany, M.D., Department of Radiology, Loyola University Medical Center, Maywood.

This 52-year old man had occult blood in the stool. Barium enema shows a sigmoid lesion.



Figure 1—Spot film during barium enema shows a filling defect of the ascending colon (arrows) with a reticular appearance.

Your diagnosis?

(1) Villous tumor
(2) Ulcerated carcinoma
(3) Lymphoma
(4) Carcinoid tumor

(Continued on page 352)

Right from the start in hypertension...



One Person Can Make a Difference

My fellow students question me, as a student delegate to the AMA-MSS, about what the AMA can do for them individually. Some of my colleagues seem to believe that the AMA is too large an organization to stop and listen to one individual. Well, the AMA listened to me.

In early Spring of 1984, I developed and wrote a resolution concerning the harmful effects of ultraviolet light. Let me explain the reasoning behind this. During that year, I had noticed an increase in the number of people using the tanning solariums, and I found that they were not fully aware of the potential hazards of UV light. Therefore, through my resolution, I asked that the AMA study this subject.

I presented my resolution to the Illinois State Medical Society Medical Student Section Governing Council. It was accepted and became part of the agenda for the AMA-MSS Annual Meeting in June, 1984. The resolution was then presented to an MSS subcommitte, and subsequently presented to the AMA-MSS General Assembly. The Assembly adopted my resolution, and it was then sent to the AMA House at the June, 1984 meeting. Again, it was presented to an AMA subcommittee and subsequently submitted to the AMA general assembly. The AMA adopted the resolution with a report of the results of their study to be given at the 1985 annual meeting.

This past June the AMA Council on Scientific Affairs presented its report on the harmful effects of ultraviolet light. The report presented the harmful effects of UV light; it stated that commercial use should be discouraged, and it presented some safety guidelines for those exposed to ultraviolet light.

So, you see, one person can make a difference. ◂

Nancy A. Zamora
University of Illinois
at Rockford

OBITUARIES

****Bennett, James P.,** Chicago, died September 20, 1985 at the age of 88. Dr. Bennett was a 1928 graduate of Rush Medical College, Chicago.

***Cahan, Aaron S.,** Chicago, died September 30, 1985, at the age of 71. Dr. Cahan was a 1940 graduate of the University of Health Sciences/Chicago Medical School.

****Collins, Richard K.,** Green Valley, Arizona, (formerly of Aurora) died October 2, 1985 at the age of 88. Dr. Collins was a 1922 graduate of the Creighton University School of Medicine, Omaha, Nebraska.

****De Takats, Geza,** Evanston, died October 3, 1985 at the age of 92. Dr. De Takats was a 1915 graduate of the Orvosi Fakultas Tudomanyegyetem, Budapest, Hungary.

****Greeley, Paul W.,** La Jolla, California (formerly of Winnetka), died September 21, 1985 at the age of 83. Dr. Greeley was a 1928 graduate of the Northwestern University Medical School, Chicago.

***Litsey, James J., Jr.,** Alton, died September 6, 1985 at the age of 55. Dr. Litsey was a 1959 graduate of the Facultad de Medicine de la Universidad Nacional Autonoma de Mexico, Mexico.

Lundeberg, Palmer O., San Diego, California, (formerly of Park Ridge) died September 2, 1985 at the age of 68. Dr. Lundeberg was a 1946 graduate of the University of Illinois College of Medicine, Chicago.

****Madsen, H. Vernon,** Holiday, Florida (formerly of Ottawa and Rockford), died September 20, 1985 at the age of 75. Dr. Madsen was a 1935 graduate of the University of Iowa College of Medicine, Iowa City, Iowa.

***Markiewicz, Simon V.,** Chicago, died September 28, 1985 at the age of 70. Dr. Markiewicz was a 1941 graduate of the Loyola University Stritch School of Medicine, Maywood.

***Miller, George A.,** Urbana, died September 30, 1985 at the age of 65. Dr. Miller was a 1944 graduate of the University of Iowa College of Medicine, Iowa City, Iowa.

***Olson, James C.,** Riverside, died September 7, 1985 at the age of 50. Dr. Olson was a 1960 graduate of the University of Illinois College of Medicine, Chicago.

***Silbar, Eliot L.,** Highland Park, died October 2, 1985 at the age of 52. Dr. Silbar was a 1961 graduate of the University of Louisville School of Medicine, Louisville, Kentucky.

***Terry, Richard M.,** Kewanee, died September 15, 1985 at the age of 61. Dr. Terry was a 1951 graduate of the St. Louis University School of Medicine, St. Louis, Missouri.

***Wedig, John H.,** Alton, died September 10, 1985 at the age of 72. Dr. Wedig was a 1938 graduate of the Washington University School of Medicine, St. Louis, Missouri.

****Wente, Constantin F.,** Dundee, died September 11, 1985 at the age of 84. Dr. Wente was a 1933 graduate of the University of Illinois College of Medicine, Chicago.

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SPRINGFIELD MEMO

A periodic update on new activities and regulations emanating from State of Illinois governmental agencies

ERRATA

Two errors occurred in publication of the September issue "Springfield Memo" (Vol. 168:3, 175, 1985). The column's section on disciplinary orders included the names of "Reya Mashayeski" and "Kirit Solanski." These names were misspelled. The correct names should have been "Reza Mashayekhi" (Lic. # 3 036-49583) and "Kirit Solanki" (Lic. # 036-062910 & 003-036-062910). The editors apologize for these errors.

From the Department of Registration and Education (DRE)

Medical Disciplinary Orders

- *Harry Bergmann* (Lic # 036-27204 & 003-036-2704)
 Effective September 8, 1985, Dr. Bergmann's controlled substance license was revoked. His medical license was also revoked, but that order was stayed, and his medical license was placed on probation with certain conditions.
- *Antonio C. Camacho* (Lic #003-036-046846 & 036-046846)
 On September 25, 1985, Dr. Camacho's medical and controlled substance licenses were revoked for a minimum of one year.
- *Harold Wayne Hammatt* (Lic. # 36-22515 & 3-36-22515-1)
 Effective August 26, 1985, Dr. Hammatt's medical and controlled substance licenses were revoked.
- *Ekhiel F. Khait* (Lic. # 036-64049 & 003-036-64049)
 On August 4, 1985 Dr. Khait's medical license was indefinitely suspended for a minimum of 18 months. His controlled substance license was suspended for not less than five years.
- *Isadore Mallin* (Lic. # 003-036-018719-1)
 Effective July 30, 1985, Dr. Mallin's controlled substance license was revoked.
- *Arthur R. Marks* (Lic. # 36-25604 & 3-36-25604-1)
 On August 26, 1985, Dr. Marks' controlled substance license was suspended, but the suspension was stayed and his license was placed on probation subject to certain conditions.
- *Samuel Matlin* (Lic. # 036-031534)
 On July 9, 1985, Dr. Matlin's medical license was restored to active status.
- *Donald Glenn Rumer* (Lic. #36-35626 & 3-36-35626-1)
 Effective August 26, 1985, Dr. Rumer's medical and controlled substance licenses were placed on probation for one year.
- *Helmuth Stahlecker* (Lic. # 036-34162)
 Effective August 4, 1985, Dr. Stahlecker's medical license was placed on probation for 2 years and he agreed to stop practicing obstetrics and gynecology.
- *Milton Steinburg* (Lic. # 036-16356 & 003-036-16356-1)
 On July 30, 1985, Dr. Steinburg agreed to voluntarily surrender his medical and controlled substance licenses.
- *Rama Sundaresh* (Lic. # 036-064139 & 003-036-064139)
 Effective July 29, 1985, the controlled substance license of Dr. Sundaresh was suspended pending a later hearing.
- *Mira Tomasevic* (Lic. # 036-61721 & 003-036-61721)
 On August 9, 1985, Dr. Tomasevic's medical and controlled substance licenses were summarily suspended pending a later hearing.

(Source: Orders signed by Director of Registration and Education)

From the Department of Labor (DOL)

Illinois Employee Right-to-Know Law Toxic Substances Disclosure

This law gives physicians the right to request MSDS (Material Safety Data Sheets) for toxic substances to which their patients may have been exposed. An MSDS describes the chemical nature, safe handling procedure and chronic/acute health hazard data of various substances.

Employers who are required to have MSDS forms on file are obligated to make this information available to "treating health care professionals" within 10 days of a written request. If an employer has an MSDS on a substance, it must be given on request of a physician, even if the substance is not on the Department of Labor's Right-To-Know Toxic Substance list.

Since the law went into effect in January 1984, the Department of Labor has received several inquiries for

MSDS sheets so that a physician could provide proper medical care. In many instances, the speed with which the information is obtained determines the quality of care, so physicians are urged to request the MSDS directly from a patient's employer.

Speakers from DOL are available to address county societies or hospital medical staffs on this law. For more information, or to schedule a speaker, contact Paul Fudacz, Toxic Substances Division, Department of Labor, 217/782-4102.
(Source: Correspondence from Paul Fudacz, DOL)

From the Department of Public Health (IDPH)

Revised Rules on Control of Tuberculosis

IDPH, with the recommendation of its Tuberculosis Advisory Committee, and with the approval of the Medical Determinations Board, has issued a revision of the rules governing the control of tuberculosis. The changes bring the state's rules in line with those of the Public Health Service and the American Thoracic Society recommendations.

Provisions most significant to practicing physicians include:

1) Most new residents of long-term care facilities must have a Mantoux tuberculin skin test. Because of the possibility of fading of skin test reactivity, the Mantoux test must be repeated within three weeks, if the initial reaction is non-significant (usually, less than a 10mm of induration).
2) Employees of hospitals, child care centers, foster home families and long term care facilities must have a Mantoux test by the same method, with certain exceptions.
3) Attention to signs and symptoms and recognition of any exposure to known tuberculosis patients, are the most important follow-up measures.
4) Reporting of cases, or of detection of the mycobacterium in the laboratory, remains required.

A copy of the revised rules may be obtained from IDPH, 535 West Jefferson, Springfield 62761.
(Source: Correspondence from Chief, Division of Disease Control)

Recommendations on Meningococcal Polysaccharide Vaccines

IDPH has endorsed the recommendations of the Immunization Practices Advisory Committee of the Public Health Service on the use of meningococcal polysaccharide vaccines (Morbidity and Mortality Weekly Report, 34:18, 255-9, May 10, 1985).

Please note, as stated in these recommendations, that these vaccines are not for routine immunization of children but may be appropriate in special risk or in the presence of an outbreak of meningococcal disease due to one of the serogroups represented in the vaccine. For copies of these recommendations, or additional information on the use of the vaccine, physicians may call or write the regional office of the IDPH, local health department or the IDPH Office of Communicable Disease Program (217/782-2016).
(Source: Correspondence from Chief, Division of Disease Control)

Medical Staff Composition

The Hospital Licensing Board has approved new language clarifying who can serve on the medical staff of an Illinois hospital. The revised licensing rules, which now must be published for public comment prior to implementation, clearly state that only medical doctors, osteopathic physicians, dentists and podiatrists may be appointed to a hospital's medical staff. This would not prohibit a hospital from appointing other types of licensed health practitioners to an allied staff.
(Source: August 1, 1984 meeting of Hospital Licensing Board).

HTLV-III Antibody Testing

IDPH has accepted recommendations from the Medical Determinations Board (MDB), the medical advisors to the director of Public Health, to revise the state policy that currently prevents blood banks from disclosing the results of HTLV-III antibody tests to donors. The Board adopted the recommendations of the Blood Banking Steering Committee (a group of blood center representatives that advises ISMS on blood banking issues).

Among other items, the MDB called for IDPH to activate its alternative test site plan to use the state lab to perform HTLV-III antibody tests (ELISA and Western blot) on the request of private practitioners and public health clinics by December 1, 1985, and to permit blood banks to notify Western blot positive donors 60 days after the implementation of the alternative test site program.
Emergency rules to adopt these recommendations will be developed by IDPH.
(Source: October 9, 1985 meeting of Medical Determinations Board)

Quality Assurance in Ambulatory Center Laboratories

At its September meeting, the Clinical Laboratory and Blood Banking Advisory Committee decided to look at the problem of assuring the quality of lab work done in physician offices, HMOs, ambulatory surgical treatment centers, hospital-owned ambulatory care centers and free standing emergency centers.

A multi-tiered system using various degrees of registration, inspection and licensure will be considered at its next meeting.
(Source: September 18, 1985, meeting of Clinical Laboratory and Blood Banking Advisory Board)

ISMS Auxiliary Sponsors Conference on Teen Suicide

Adolescent and teen suicide was the subject of a day-long program sponsored by the Illinois State Medical Society Auxiliary (ISMSA) on September 12, 1985, at the Drake Hotel, Chicago.

Speakers described adolescent and teen suicide as a growing problem in today's society. According to 1983 estimates of the National Center for Health Statistics, the suicide rate among youths has tripled in the past 25 years. Five thousand young people, an average of one every 90 minutes, take their lives each year.

Panelists told the group that young people often give signs which demonstrate their need for help. Parents, teachers, social workers, clergy and health care professionals discussed these signs, how to deal with them and how to increase community awareness at the seminar.

Role of the Medical Profession

The medical profession is taking the lead in dealing with the problem of teen suicide, L. David Zinn, M.D., director of child and adolescent psychiatry at Michael Reese Hospital and clinical associate professor at the University of Chicago, told conference participants. "The role of the professional is crucial in the treatment of adolescents," stated Dr. Zinn. He outlined several clinical research projects now under way in the psychoanalytic area which study the severity of the problem. Physicians have become active in both the prevention of teen suicides and the treatment of teens. "Our main goal is to interrupt the self-destructive behavior of teens," said Dr. Zinn.

Why More Suicides Today?

John K. Larson, M.D., Libertyville, president of the Neuropsychiatry Associates of Illinois, cited case histories to explain the recent increase in teen suicides. Comparing adolescents of 25 years ago with adolescents today, Dr. Larson outlined several reasons for this increase.

First, he cited a change in the sense of "rootedness" among adolescents today. Families are more mobile, he said, which causes general feelings of transience. Dr. Larson also pointed to the declining roles of religion and the absence of modern heroic figures in today's society. In the past there was a "sense of conscience" for youths to use as a guideline for decisions, he said, adding that hero worship provided young people with role models and cultural reinforcement of a sense of right and wrong.

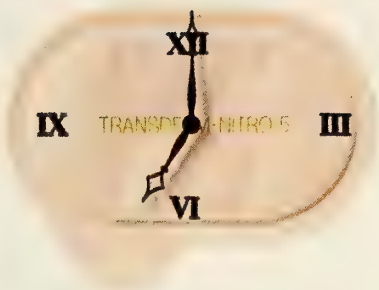
Problems, such as a romantic break-up or death of a parent, relative or friend, coupled with increasing divorce rate, were said to contribute to the teen suicide problem. Adolescents begin to see human relationships as non-permanent, he said. The increased use of drugs and alcohol among teens is also a problem, according to Dr. Larson. "Drugs and alcohol become a method of self-medication to relieve depression involved with these sorts of problems," he told the group. "It is imperative we shift the balance toward life and away from death."

Warning Signs of Suicide

Suicide is usually premeditated, according to Carol Felsenthal, coauthor of the book A Cry for Help. Felsenthal's book describes the suicide-prone teenager, alerts parents to specific warning signals and advises parents what to do in a suicide crisis. This speaker cited frequent behavior changes in teens which may warn of a potential suicide attempt. Warning signals included extreme aggressiveness or passivity, changes in eating or sleeping habits, apathy and lack of interest in school work, substance abuse, suicide threats and giving away of personal possessions.

"Most teens and adolescents who commit suicide want to live," stated

(Continued on page 324)



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Intolerance of organic nitrate drugs, marked anemia, increased intraocular pressure or increased intracranial pressure.

WARNINGS
In patients with acute myocardial infarction or congestive heart failure, Transderm-Nitro system should be used under careful clinical and/or hemodynamic monitoring.
In terminating treatment of anginal patients, both the dosage and frequency of application must be gradually reduced over a period of 4 to 6 weeks to prevent sudden withdrawal reactions, which are characteristic of all vasodilators in the nitroglycerin class.
Transdermal nitroglycerin systems should be removed before attempting defibrillation or cardioversion because of the potential for altered electrical conductivity which may enhance the possibility of arcing, a phenomenon associated with the use of defibrillators.

PRECAUTIONS
Symptoms of hypotension, such as faintness, weakness or dizziness, particularly orthostatic hypotension may be due to overdosage. When these symptoms occur, the dosage should be reduced or use of the product discontinued.
Transderm-Nitro system is not intended for immediate relief of anginal attacks. For this purpose occasional use of the sublingual preparations may be necessary.

ADVERSE REACTIONS
Transient headaches are the most common side effect, especially when higher doses of the drug are used. These headaches should be treated with mild analgesics while Transderm-Nitro therapy is continued. When such headaches are unresponsive to treatment, the nitroglycerin dosage should be reduced or use of the product discontinued
Adverse reactions reported less frequently include hypotension, increased heart rate, faintness, flushing, dizziness, nausea, vomiting, and dermatitis. These symptoms are attributable to the known pharmacologic effects of nitroglycerin, but may be symptoms of overdosage. When they persist the dose should be reduced or use of the product discontinued.

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Therapy should be initiated with application of one Transderm-Nitro 5 system to the desired area of skin. Many patients prefer the chest; if hair is likely to interfere with system adhesion or removal, it can be clipped prior to placement of the system. Each system is designed to remain in place for 24 hours, and each successive application should be to a different skin area. Transderm-Nitro system should not be applied to the distal parts of the extremities
The usual dosage is one Transderm-Nitro 5 system every 24 hours. Some patients, however, may require the Transderm-Nitro 10 system. If a single Transderm-Nitro 5 system fails to provide adequate clinical response, the patient should be instructed to remove it and apply either two Transderm-Nitro 5 systems or one Transderm-Nitro 10 system. More systems may be added as indicated by continued careful monitoring of clinical response. The Transderm-Nitro 2.5 system is useful principally for decreasing the dosage gradually, though it may provide adequate therapy for some patients when used alone.
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Teen Suicide

(Continued from page 322)

Felsenthal. Repeated warnings are used to force someone to pay attention. "These kids hope parents and friends will tune in."

Teens Need to Feel Comfortable

William E. Porter, Ph.D., director of mental health, Cherry Creek school district, Englewood, Colorado, reiterated the importance of parental and community involvement in suicide crisis prevention. Porter felt adolescents need to have a "comfortability factor" in their lives. Parents and friends must be accessible to teens and not pressure them with high expectations.

According to Dr. Porter, "kids need to spend time with 'safe' people, such as bus drivers, custodians and librarians." These people serve as community resource contacts and provide a stability that adolescents need in their lives.

"Kids just want somebody to listen to them; they want to feel valuable and helpful," Dr. Porter told the group. As part of this communication exchange, parents and peers need to help teens develop strategies to cope with stress, disappointment, the possibility of failure or the fear of success. Sometimes, he added, medical professionals can help to teach this coping process.

Communication Helps Parents

Support groups, such as the Compassionate Friends, help families and friends who have experienced the death of a child. According to Bill Churchill, a group member whose son committed suicide in 1977 at age 16, participation in such a support group helps parents deal with the reality that their child is actually dead. "Recovering from the devastating death of a child is not a short process," said Churchill. "The object of the group is to tell people that they don't have to be alone. There's someone you can share with."

The seminar is part of the Auxiliary's ongoing educational program on teen suicide. Many local medical auxiliaries will be sponsoring similar programs in their communities.



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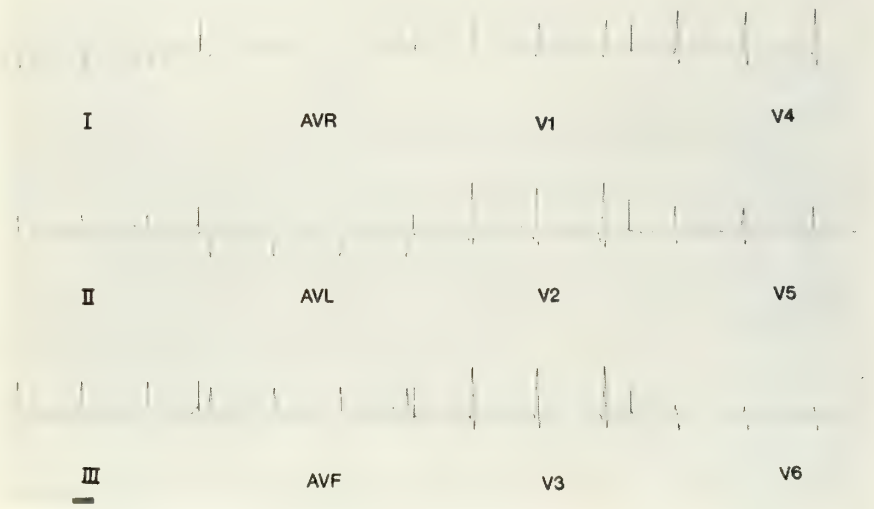
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EKG OF THE MONTH

Contributing Editor John F. Moran, M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine



This is a 45 year old woman who had first developed severe dyspnea on exertion. She had been given digoxin and furosemide and improved. Two years later, while still taking this medication, she again developed dyspnea on exertion with pedal edema. The day of admission, she complained of severe midsternal chest pain radiating to the left shoulder and back. It had begun while she was typing and was not associated with any dyspnea, diaphoresis, or palpitations. The pain had been present for two hours when she came for an examination.

She was admitted to the hospital where nitroglycerin and nifedipine failed to relieve the pain. Finally, morphine relieved the pain. Her physical examination showed a blood pressure of 120/70mmHg, a pulse of 80 beats per minute, and respirations of 18 per minute. Jugular venous distension was increased and the carotid arterial pulse was small with a normal upstroke. Lungs sounded normal to auscultation. Examination of the heart showed a right sternal border impulse and a palpable ventricular gallop. The first sound was normal but the second sound was loud and a grade 3/6 systolic murmur was heard at the left sternal border, fourth and fifth interspaces. A chest x-ray revealed cardiomegaly with a prominent main pulmonary artery. This twelve lead ECG was obtained.

Questions:

1. **The 12 lead ECG shows:**
 - A. Right axis deviation.
 - B. An acute myocardial infarction.
 - C. Severe right ventricular hypertrophy.
 - D. Left anterior hemiblock.
 - E. First degree atrioventricular block.

2. **The following statement(s) is/are true.**
 - A. The diagnosis here requires hemodynamic measurement.
 - B. Pulmonary emboli should be considered.
 - C. Vasodilator medication can be useful.
 - D. Echocardiography can help differentiate congenital heart disease from valvular heart disease in this setting.
 - E. All of the above.

(Continued on page 356)

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For Brief Summary, please see following page.

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Contraindications: Hypersensitivity to the drug; psychosis, acute or chronic, regardless of etiology.

Precautions: *Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing HYDERGINE (ergoloid mesylates) preparations.*

Adverse Reactions: Serious side effects have not been found. Some transient nausea and gastric disturbances have been reported, and sublingual irritation with the sublingual tablets.

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Physician Impairment Focus of Conference

Helping physicians whose ability to practice is impaired by alcoholism, drug dependence, psychiatric or physical disorders was the focus of the Midwest Conference on the Impaired Physician held September 21, 1985, at the ISMS offices in Chicago.

The Illinois State Medical Society and the Illinois Council on Continuing Medical Education sponsored the event, which drew participants from the Illinois, Indiana, Ohio, Missouri and Wisconsin state medical societies. Physicians and personnel from impaired physician programs of these midwestern states exchanged ideas about methods to help impaired colleagues return to regular practice.

Communication, Prevention Are Key

James W. West, M.D., medical director for the Betty Ford Center in Rancho Mirage, California, gave the keynote address. Dr. West, who was the founding chairman of the ISMS Committee for the Impaired Physician, stressed awareness and sensitivity. The best form of treatment for impaired physicians is prevention, he told the group, suggesting that physicians need formal education about drug and alcohol dependency. Dr. West recommended that hospital medical staff members build active personal and confidential relationships with medical students and residents. Open communication, he said, is essential in prevention of drug and alcohol dependence.

"The diagnosis is always later than it should be," noted Dr. West, as he outlined the symptoms of impairment. These can include one or more of a combination of the following: drunk driving charges, intoxication at social gatherings, neglect of ordinary medical staff duties, unexplained absence, inappropriate or dangerous medical orders, patient complaints or careless prescription orders. Although "the motivation to get unhooked is greater with physicians than with non-physicians," said Dr. West, "impaired physicians need to be monitored for the rest of their lives."

Dr. West told the group that help is available for impaired physicians and the prognosis for cure among doctors is good. State programs are necessary to help rehabilitated physicians with re-entry into practice, according to West. "I am impressed by the number of people who want to reach out and help doctors," he concluded.

Participants spent the remainder of the day in roundtable discussions on such topics as verification of impairment, educational activities for professional groups, intervention techniques, monitoring and advocacy activities, relations with state licensing and disciplinary boards and development of medical student and resident programs.

The meeting concluded with a panel discussion on strategies for developing an impaired physician program with a part or full-time medical director. Speakers represented the Florida, New York, Pennsylvania and New Jersey impaired physician programs.

ISMS Program

ISMS has staffed a Committee for the Impaired Physician since 1977. Committee members offer guidance and advice to impaired physicians and those who care about them. They participate in interventions and referrals to secure a positive outcome. All contacts with the ISMS Committee for the Impaired Physician are confidential. Persons wanting information or assistance should call the ISMS Division of Medical Services at (312) 782-1654.

It is expected that the conference will become a regular event among midwest state medical societies.

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Assessing Suicide Risk

By Abd El Aziz A. Salama, M.D./Springfield

Suicide is a major public health problem. The United States Public Health Service reports that about 30,000 Americans commit suicide each year, making suicide the ninth overall cause of death. Professionals who work more closely with suicidal patients estimate that the actual numbers of suicides may be as high as 90,000 per year. Suicide is also the second most common cause of death in college campuses, the leading cause of death among medical students, and the third highest cause of death among teenagers.

This paper was first presented at the SIU School of Medicine Symposium to Family Medicine Practitioners, "The Many Faces of Depression," on October 21, 1983.

Suicidal behavior is becoming an increasingly accepted mode of expressing interpersonal and intrapsychic distress. It is one of the ten leading causes of death and the prevalence of suicide attempts appears to be increasing rapidly. Some estimates have suggested that over 250,000 suicides occur annually, with 50 unsuccessful attempts for each successful suicide. This is noteworthy, since a decade ago, we were taught that one suicide attempt in four is successful.

Liberman and Eckman found that a group of repeated suicide attempters were not in the throes of life crisis but were devoid of social and emotional skills and used suicidal gestures as a maladaptive pattern in a manipulative lifestyle to control social relationships.[2] Frequently, psychiatric patients are deficient in both skills and interpersonal relationships, thus increasing the likelihood of suicide. Advanced age, physical illness, and pain further increase this potential.

A large part of our problem involves the uniqueness of each individual. A full understanding of the suicidal impulse in a given person can only be reached by a thorough knowledge of that person. This uniqueness prevents us from readily translating our understanding into a valid, readily generalized principle.

Typical Meaning of Suicide

The meaning of a suicide can be determined only after a lengthy investigation, one that must deal simultaneously with the personality of the subject and his familial, local and social environment.

Beachler,[3] tried to distinguish several typically distinct situations where a person might consider suicidal action to be an adequate solution. He distinguished eleven types of suicide, grouped together in four more general categories. These types are neither causes nor motives. They are, in contrast, strategic situations.

Escapist Suicides

These include all cases of suicide where the general meaning or sense of the act is to take flight, where, in consequence, suicide appears as a means to escape something.

Flight—To commit a suicide for flight is to escape by taking one's own life from a situation sensed by the subject to be intolerable. In order to flee, one does not have to intend an absolute death; a relative and temporary death is sometimes enough. Sleep is, in fact, the best possible solution, and since the means of inducing sleep voluntarily exist, why not use hypnotics?

Grief—Suicide whose meaning is grief occurs when a subject takes his own life following the loss of a central element of his personality or way of life. Grief could be the result of the loss of a loved object, the loss of a physical or intellectual integrity, the loss of social position or the loss of faith in a cause.

Self-punishment—To commit punishment suicide is to make an attempt on one's own life in order to atone for a real or imagined fault.

Aggressive Suicide

This is suicide as an act of aggression perpetrated against another; by killing oneself or by trying to do so, the subject seeks to harm somebody else.

Crime—A suicide whose meaning is crime involves making an attempt on one's own life by involving another in one's death.

Vengeance—Suicide whose meaning is vengeance is intended either to provoke another's remorse or to inflict the disgrace of the community on him.

Blackmail—Suicide whose meaning is blackmail intends to put pressure on another by depriving him of something he holds dear. Blackmail brings four elements into play: two people (one makes the demand and the other is the victim) and two goals (one claimed by the person making the demand and the other threatened by him and retained by the victim).

Appeal—This is not absolutely distinct from blackmail. In both cases, what is involved is risking one's life to obtain something which remains vague and general. The strategy in appeal is to risk one's life to obtain the care or affection of another.

Oblative Suicides

Sacrifice—Suicide whose meaning is sacrifice involves an attempt on one's own life in order to save or to give a value judged superior to one's own life.

Transfiguration — This suicide seeks to attain a state considered by the subject to be infinitely more delightful. An example is religious transfiguration, in which suicide assumes two different meanings. Either it represents a direct access to a beyond that is judged preferable to the present, or it is the outcome of an ascetic exercise that tends to incorporate the entire movement of one's life.

Ludic Suicides

Self-destruction can take its meaning as what we can call ludic type.

Ordeal—An ordeal entails risking one's life in order to prove oneself to oneself or to solicit the judgment of others. The subject challenges probability by agreeing to enter into a situation where the chances of perishing are neither zero nor certain, or he acts on the probabilities. Death is always possible, without being certain.

Game—Suicide as a game involves taking a chance on killing oneself where the sole purpose is to play with one's own life. The subject does not seek to prove something, either to himself or to others. Danger is courted for its own invitation or of instability of perception.

It is clear that within each category meanings can encroach on each other because they have a common basis, *e.g.*, every suicide from grief is a flight, although every flight is not the result of grief. Flight is a part of most suicides because, from the very fact that they are solutions obtained by the removal of the subject, the subject seeks to escape from reality. This aspect may be called the general tonality of suicide.

Risk Factors in Suicide

The physician should be acquainted with the following ten major risk factors which predict the possibility of eventual suicide:

Sex—Women attempt suicide three times more frequently than men, but men actually kill themselves more than three times as often as do women.[1]

Age—There is a bimodal distribution of suicide which peaks in the late teenage and elderly years.[1] The high-risk category includes males 45 or more years of age. Patients 19 or younger, or 45 or older, are considered higher risk for suicide.

Depression—Affective disorders are a significant factor in 12%-60% of suicides. The average suicide rate was 30 times greater in depressives compared to the general population and 15% of primary depressives die by suicide.[4]

Previous attempt—25% to 50% of persons who kill themselves have previously attempted to do so. A prior attempt not only increases risk in the year following the attempt, but also increases the subsequent lifetime suicide rate.[5]

Alcohol and Drug Abuse—It is estimated that 15% of all alcoholics commit suicide, the suicide often coming as a late complication of chronic alcoholism correlating well with the occurrence of cirrhosis.[6]

Rational Thinking Loss—Any psychosis in a patient suffering from schizophrenic, bipolar illness or organic mental disorder presents a hazard to the patient if judgment and rational thought are severely impaired and if he or she is delusional or hallucinating. It is difficult to establish rapport and trust with these individuals, not to mention the ever present danger of their hearing noises with instruction to hurt or kill themselves.[6] In one study, schizophrenic patients who committed suicide were found to be unemployed, friendless, unhappily dependent on an overprotective family, and sexually unadjusted, with many homosexual fears.[7]

Social Supports Lacking—The suicidal patient is often lacking relatives or friends, employment at a meaningful job and religious support.

Organized Plan—The person with a well-delineated specific plan, envisaging a lethal available method is at a far greater risk than others.[8] The extent of planning of the attempt and the lethality of the plan are both factors requiring greater degrees of organization.

No Spouse—Divorced, widowed, separated, or single patients have a greater risk of suicide than married patients, especially those with children to reinforce the marriage.

Sickness—Chronic, debilitating and severe illness is thought to be a definite risk factor. Suicidal patients often seek medical attention prior to their act. Illness is often directly involved in the outcome.

Identifying Suicide Potential

While it is recognized that a physician cannot absolutely predict whether a patient will commit suicide, he is regularly expected to make decisions based on such predictions. Many nonpsychiatrists are frightened by or uncomfortable with patients who verbalize or act out suicidal intent, and they are anxious to delegate this decision-making responsibility to someone else. Psychiatric studies of suicide in the past have been made largely on attempted suicides on selected cases of completed suicide. The pitfalls of forming conclusions about com-

pleted suicides from studies of attempted suicide are obvious, since a number of recent studies indicate that attempted suicide and completed suicide are actions taken by people who differ psychologically.[9]

Does the history of previous attempts suggest serious suicidal risk? The fact that nearly one-third had made prior attempts suggests that such attempts have some predictive value. However, the number of reported attempted suicides in several studies was several times the number of completed suicides. Therefore, only a minority of those who attempt suicide later on commit suicide. No long term follow up studies of subjects who have attempted suicide have been made in this country. One study in France, extended over 18 years, showed that only 12% of attempted suicides ultimately killed themselves.[10]

However, numerous clinical scales are now available for assessing the suicide potential of patients.[11] Tuckman and Youngman,[12] derived a 17-factor system for identifying high and low-risk patients. Litman and Associates,[8] studied profiles of telephone callers to the Los Angeles Suicide Prevention Center to develop a 15-item scale of suicidal risk. Beck *et al.*,[13] prepared the Scale of Suicidal Ideation which involved 19 items. Weisman and Warden,[10] developed the Reserve Rating Scale for suicide prediction. The "SAD PERSON SCALE," was derived by William Patterson, *et al.*[14] (See Table 1).

The "SAD PERSON SCALE" is a simple test that can be administered by the physician who initially evaluates the suicidal patient in his office, emergency room or general hospital. It is easy to remember and positively influences the examiner's assessment of potentially suicidal patients. Medical students who were taught the scale demonstrated a significantly greater ability to accurately evaluate and make recommendations for disposition of low-risk and high-risk patients.

The "SAD PERSON SCALE" is a device to assist memory in recalling a set of facts. It is easy to learn, and gives the physician in an emergency situation a sense of confidence in decision-making. It ensures that he or she has considered each factor accepted as important in assessing suicide potential. It also serves as a bridge to the development of clinical experience in dealing with the suicidal patient. The "total score" is used in decision-making, and is intended to correlate with clinical assessment and disposition. (See Table 2)

Table 1
Sad Person Scale:

S	Sex
A	Age
D	Depression
P	Previous Attempt
E	Ethanol Abuse
R	Rational thinking loss
S	Social support lacking
O	Organized plan
N	No Spouse
S	Sickness

One point is scored for each factor present (0-10).

Table 2

Total Points	Prepared Clinical Action
0 to 2	Send home with follow up
3 to 4	Close follow up, consider hospitalization
5 to 6	Strongly consider hospitalization
7 to 10	Hospitalize or commit

Who Commits Suicide?

The recent loss of love objects is defined as the loss of a family member by death, separation, or divorce in the year preceding the patient's suicide. In some subjects, grief reactions had begun more than a year before the suicide.

The judgment was made that an illness could be attributed to the suicide or suicide attempt, when there was evidence that the patient had expressed sadness, despair or hopelessness in connection with a physical illness or its consequences. Particularly pertinent are psychosomatic illness, cardiovascular and heart diseases and malignancies.

Among the psychosomatic disorders there were unusually high rates of peptic ulcerations, rheumatoid arthritis, and hypertension. All patients had shown evidence of depression. Several patients talked of an inability to bear more pain. Those disabled by crippling disease had made comments indicating that life had little meaning for them if they could not work or move about.

Suicide is a significant factor in the long-term outcome of both schizophrenia and primary affective disorders. It is evident that depressive individuals are strikingly more prone to suicide than other psychiatric syndromes. In several studies, affective disorders were associated with very high suicide rates,[15] approximately 30 times that seen in the general population. Mayan,[16] has pointed out that, "It has long been recognized that the stages of onset and recovery in depressive illness may be particularly associated with suicide risk." Sainsbury,[17] estimated that one in every six patients diagnosed as manic depressive will die from suicide.

The Noreilk report,[12] examined the pattern of frequency of suicide in the year following the final stay in the hospital. His findings show that the frequency of suicide was directly greater in the first year following discharge. In another study,[18] 75% of suicides occurred within six months after discharge, 20% occurred between 6 to 12 months, and 5% occurred within 30 months after discharge.

Little is known about the causes of suicide in schizophrenics, but there are risk factors. These include being young, male, having a chronic relapsing illness, having been depressed in the past, being currently depressed, being admitted for suicidal ideation, having recently changed from inpatient to outpatient care and being unemployed.[19]

Persistent auditory hallucinations may lead some chronic schizophrenics to commit suicide.[20]

Chronic alcoholism was diagnosed in suicidal patients in accordance with the definition of Keller,[21] "alcoholism is a chronic behavioral disorder manifested by repeated drinking of alcohol bever-

Table 3
Method Used By Suicide Subjects

Method Used	Percent of Subjects
Firearms	10
Hanging	15
Asphyxia	12
Poison or drugs	10
Drowning	7
Jumping	5
Cutting	5
Two or more methods	4
Other methods	2

ages in excess of the dietary and social uses of the community and to an extent that interferes with the drinker's health, or his social or economic functioning." In attempting to establish this diagnosis it is often important to obtain a history from the family as well as from the patient. The duration of the illness varied in this group from seven to 46 years, with a mean and median duration of 20 years.[22] The importance of this finding is that suicide infrequently occurs in the early stages of chronic alcoholism. The danger of suicide in alcoholism is, therefore, largely confined to the later periods of the disease.

Childhood and Adolescent Suicide

Over the past decade the number of studies among children and adolescents has grown, prompted in part by the alarming increase in suicides among younger age groups.

According to the latest government statistics, suicide in youth ages 15 to 24 increased by 24% between 1961 and 1978 (U.S. Dept. of Health and Human Services, 1980).

Pfeffer and his group,[23] did a study over 28 months on a group of young children between the ages of 6 and 12 and gave the following conclusions:

- No significant correlation was found between sex, race or ethnicity and suicidal behavior.
- Suicidal thoughts and methods most common to this age group were, in order of prevalence: jumping from heights, stabbing, hanging, ingestion, burning and running into traffic.
- 60% of the children had a history of parental separation and/or divorce.
- All children who had affective disorders were also suicidal.
- It has to be noted that: although intense depression is frequently a sign of a suicidal tendency in children, intense aggression may also indicate possible suicidal tendencies. Suicidal behavior and assaultive behavior are multidetermined and require assessment of not only the child but also his parents.[24]

Prevention

The best intervention for suicide is prevention, which depends on prompt and thorough evaluation of the potentially suicidal patient.

Suggestions concerning the prevention of suicide have arisen chiefly from statistical studies of coroners' records[25] from studies of patients who have been hospitalized and who commit suicide in the hospital or shortly after discharge, from the reports of psychiatrists based on their experiences with their own patients,[19] and from studies of attempted suicides.[9] These suggestions have, in general, been of value in helping to define more clearly the problem in preventing suicide.

There are three basic approaches to preventing suicide in patients.

The first is to physically prevent the act, by locking patients up, watching or restraining them, removing harmful objects, etc.[4] This has been the traditional approach with patients on suicidal precautions. However, these precautions are all somewhat demeaning and infantilizing, and they put the treatment staff against the patients, to see who can outwit the other. There are also practical limits to the number of persons who can be kept under such precautions and to the duration of enforcement.

The second approach is to remove the distress or dysphoria that is feeding the suicidal urge. This goal might be achieved by social changes, medication, psychotherapy or other treatment or rehabilitative measures. Such an approach has the advantage of placing the treating team and the patient more nearly on the same side, both fighting the "disease," distress, or discomfort. Unfortunately not all distress, dysphoria, or misery can be removed.

The third possibility is to instill some ethical or moral barriers to the act of suicide, making such behavior less "available" to the patient. It is questionable whether this can be done in adulthood, after suicidal behavior or preoccupation has already appeared. It may work only if taught or instilled during childhood.

Each of these three approaches requires considerable time and individual attention. We need to apply them to those persons who will almost certainly commit suicide unless prevented.

It is also clear that the warning of a suicidal gesture and even of expressed suicidal intent must never pass unheeded. This is particularly the case when it occurs in a person who may be suffering from depression and when the attempt has been a serious one. It is true to a lesser extent for patients who show hysterical, psychopathic, or alcoholic symptoms, and for previously stable persons who find themselves confronted with sudden, seemingly overwhelming stress. These are cases for which the physician must keep a vigilant watch.

Malpractice Liability

The increased number of malpractice suits has had an impact on the practice of medicine. The most common suits as a result of suicide according to Messinger,[18] are:

- The failure to care for an obvious suicide risk.
- Inadequate and incomplete psychiatric evaluation.

So it is strongly advised that the findings, decisions, as well as reasons for them, should be clearly documented and stated in the

patient's records. With regard to potential malpractice liability in the case of suicide, the courts will assess if the treatment and management plans were considered therapeutic and in keeping with the needs of the patient.

Conclusions

Thus, in dealing with the suicidal patient, two often conflicting values come into play: concern for individual liberty, and concern that the individual not commit suicide. To the extent that society holds the latter concern, a psychiatric finding of high suicide risk should be grounds for further investigation and treatment. Society will have to balance the cost to civil liberties of unnecessarily confining non-suicidal patients against the cost of failing to hospitalize patients who may go on to commit suicide. In the meantime, psychiatry must learn to identify the suicidal patient as reliably and accurately as clinical judgment permits.

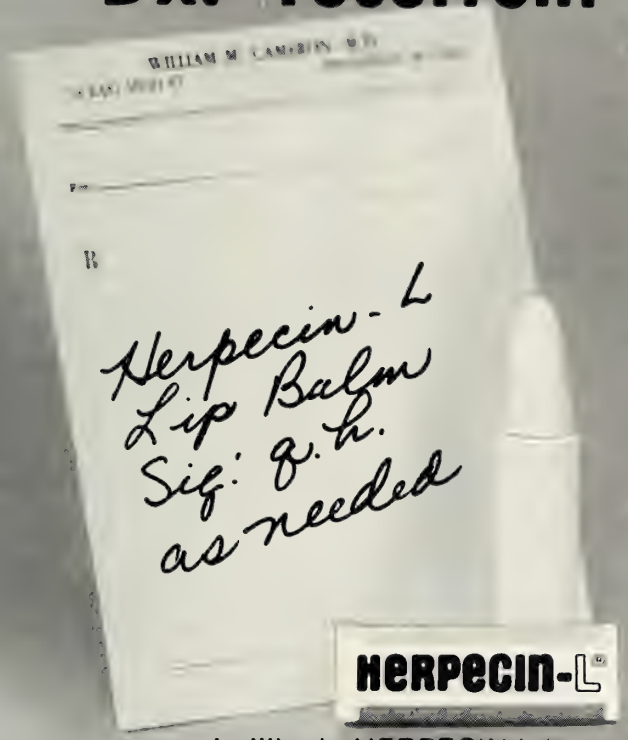
Every patient who undergoes a psychiatric examination should be carefully evaluated with regard to a suicidal potential. A determination must be made as to whether a particular patient represents a high suicide risk. High-risk patients should receive psychiatric hospitalization. Whether the patient should be placed on an open or closed ward and whether suicide precautions are indicated depends on the judgment of the treating physician.

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A complete list of references for "Assessing Suicide Risk," by Abd El Aziz A. Salama, M.D., may be obtained by writing the *Illinois Medical Journal*, Twenty North Michigan Avenue, Suite 700, Chicago IL 60602.

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Surgical Treatment

Solitary Brain Metastasis

By George R. Cybulski, M.D.
and Kelvin A. Von Roenn, M.D./Chicago

Case histories of 15 patients undergoing craniotomy and resection for single brain metastasis at our institution were reviewed. The average survival rate was 16.4 months; 47% of the group survived beyond one year. Both figures represent increases over previous studies. Significant improvement in presenting neurological symptoms occurred in 87% of the patients following surgery. Surgical morbidity and mortality were less than 1%. The literature reflects a general trend toward prolonged, symptom-free survival following craniotomy and resection of solitary metastatic cerebral lesions. These factors support an expanded role for this technique in management of oncologic patients.

Cerebral metastasis is one of the more serious complications of systemic cancer. Large specialty centers, such as the Memorial Sloan-Kettering Cancer Center in New York, report an incidence of approximately 18%.[1] More recent studies indicate that this incidence might be increasing secondary to better control of primary disease outside the central nervous system.[2,3]

Up to 40% of cerebral metastases present as solitary brain tumors. Management of these lesions is by no means standardized. Conventional whole brain irradiation and surgical excision combined with radiation represent two current forms of therapy. Surgical management of solitary intracranial metastasis is considered palliative and cure is rare. However, our experience demonstrates a potentially low surgical morbidity and mortality, suggesting that this therapeutic option should be considered more often.

Case Reports

Records of 20 patients undergoing craniotomy for a presumed single metastatic neoplasm between January, 1977, and December, 1983, were reviewed. Five patients were lost to follow-up and excluded from consideration.

The group analyzed consisted of eight patients with lung cancer, three with breast cancer, two with melanoma, one with ovarian cancer, and one with a solitary metastatic deposit of unknown origin. None had shown concurrent complications from the existing primary disease when symptoms of central nervous system involvement presented.

All patients in the group were pre-treated with dexamethasone (10mg. by mouth, or by intravenous injection initially, followed by 4mg. every six hours). Preoperative localization of a solitary lesion was confirmed in all cases with double contrast dose delayed computerized tomography (CT) brain scanning. Gross total excision was carried out in all patients. In addition, all patients underwent a postoperative course of whole brain irradiation after which steroid therapy was tapered and discontinued.

Results

The mean survival rate after craniotomy and resection was 16.4 months. The one year survival rate was 47%. The median survival rate, or the amount of time after craniotomy and resection at which half of the patients in the group were alive, was 11 months. There was no 30-day surgical mortality in the group, and surgical morbidity consisted of two minor wound infections successfully treated with antibiotics.

In the majority of the patients, preoperative neurological signs and symptoms suggested increased intracranial pressure (headache,

nausea, vomiting). Hemiparesis, confusion and seizures were also observed. These preoperative findings resolved in 87% of the patients by the first week after surgery. In the majority, resolution was maintained until death.

The longest survivor in the group was alive seven years after craniotomy for intracranial metastasis from a primary breast cancer. Another six patients from the group are still alive with a mean survival of greater than 13 months and no evidence of recurrent neurological disease.

Discussion

The median survival in a large series of patients undergoing craniotomy for resection of solitary cerebral metastasis is 7-8 months.[2,3,5] Our median survival figure of 11 months may reflect our smaller patient population. Radiation therapy alone accounts for a median survival of approximately three to six months.[1]

Our figures, as well as those from more recent studies, continue to reflect an increase in survival time after craniotomy and resection of solitary cerebral metastasis. Factors which might account for this include stricter selection of patients and earlier detection of more surgically amenable lesions with the advent of CT brain scanning. In addition, cancer patients presenting with cerebral metastases today are often recognized at a stage when the primary tumor has already been partially controlled. In our series, the mean latent interval between diagnosis of the primary carcinoma and intracerebral metastases was 36 months. Other series confirm that the disease free or latent interval and the neurologic status at the time of craniotomy for solitary cerebral metastasis are the most important prognostic factors.[2-5]

Surgical resection of a solitary cerebral metastasis from systemic cancer should be considered an important option in management of an oncologic patient. In centers skilled in this technique, it is probably more effective than a combination of steroids and radiation therapy. Surgery provides rapid and sustained relief from devastating neurologic symptoms, and, in some instances, long term survival can be achieved.

We have continued to emphasize this approach and have recently combined surgical resection with the implantation of catheters within the tumor bed for the afterloading of radioactive isotopes. At this writing, two additional patients with solitary cerebral metastasis from lung cancer have undergone this combined approach with encouraging results. ◀

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ISMS Physician Games Wrap-Up

Healthy Competition

More than 130 physicians and spouses competed in a variety of athletic events during the first annual Illinois State Medical Society Physician Games, August 23-24, at the Marriott Hotel, Lincolnshire.

Organized by the ISMS Sports Medicine Committee, the first annual ISMS Physician Games offered a host of running and swimming contests, tennis, racquetball and team volleyball competitions, and a golf tournament. Aerobics classes and a karate demonstration were also part of the day-and-a-half program. Also offered were several sports medicine sessions and a special luncheon for spouses.

- Ralph A. Nelson, M.D., Ph.D., nutrition editor of *The Physician and Sportsmedicine* and *Geriatrics,* addressed nutritional considerations for athletic performance at a presentation for physicians and discussed female nutrition at the spouse luncheon.
- A panel of Mitchell Goldflies, M.D., Howard J. Sweeney, M.D., and Preston M. Wolin, M.D., examined new treatment and rehabilitation modalities for knee injuries in sports.
- Per Olof Astrand, M.D., head of the Department of Physiology III, Karolinska institutet, in Stockholm, Sweden, made a presentation on how physical performance and athletic training are affected by aging.
- William Castelli, M.D., director of the Framingham Heart Study, addressed the implications of good lifestyle habits in the prevention of cardiovascular disease.
- George Sheehan, M.D., noted cardiologist and runner, addressed participants during the awards banquet on the importance of lifelong exercise and fitness.

The following pages feature photographs from the Games, and a list of those honored for their athletic prowess in the events. Plans already are underway for next year's event, which is expected to attract an even larger number of physician participants.

Team Physician Award Nominees Are Sought

Nominations are now being sought for the Illinois State Medical Society's annual Team Physician Award. The award is an annual program designed to recognize physicians willing to contribute their skills to young athletes in Illinois, encourage physicians to become team physicians, and highlight the importance of medical supervision of sports.

Nominees must meet the following eligibility criteria:

—Licensed to practice medicine in all of its branches;

—Tenure as a team physician at the high school or college level for a minimum of 10 years; and

—Current membership in ISMS.

Coaches, school officials, athletes, parents, other physicians, the media, civic organizations, and others may nominate a physician for the award. Retired physicians may be nominated for past team physician activities.

For further information on the Team Physician Award, contact the ISMS Division of Medical Services, Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602, (312) 782-1654. ◀

ISMS Physician Games Winners

Volleyball Tournament
1st: Rush-Presbyterian St. Luke's Medical Center, Chicago
2nd: Victory Memorial Hospital, Waukegan
3rd: Lake Forest Hospital, Lake Forest

Running Events

5000 Meter—1st Heat:
Top Runner-All Age Groups: George Sheehan, M.D., Red Bank, New Jersey (21:23.5)
46-55 Age Bracket
1st: Richard B. Eisenstein, M.D. Evanston (22:06.1)
2nd: Toussaint Toole, M.D., Chicago (22:36.8)
56-60 Age Bracket
1st: Alfred D. Klinger, M.D., Bedford Park (23:26.3)
2nd: William Castelli, M.D., Boston, MA (27:08.3)
3rd: William J. Marshall, Jr., M.D., Olympia Fields (28:44.1)
Over 60 Age Bracket
Francis Jeffords, M.D., Mundelein (28:00.6)
5000 Meter—2nd Heat:
Top Runner—All Age Groups: Craig Dean, M.D., Libertyville (16:25.5)
Under 35 Age Bracket
1st: Martin D. Hoffman, Milwaukee, WI (17:04.4)
2nd: Stephen O. Loyd, M.D., Libertyville (19:09.5)
Over 36 Age Bracket
1st: E.P. Kirch, Lake Bluff (22:48.3)
2nd: Jaime A. Galiano, M.D., Oak Brook (25:36.1)
3rd: Mitchell Goldflies, M.D., Chicago (26:53)
One Mile Run
1st: E.A. Doisy, M.D., Granite City (5:41.2)
2nd: Jaime A. Galiano, M.D., Oak Brook (6:28.9)
3rd: Allan Hirsch, M.D., Chicago (8:06.7)
4th: Hung-Shing Tsang, M.D., Aurora (8:38.7)
3000 Meter
1st: Peg Cronin Dean, Libertyville (11:40.4)
2nd: Linda Kirch, Lake Bluff (15:50.5)
3rd: Shelley C. Loyd, Libertyville (18.52.8)

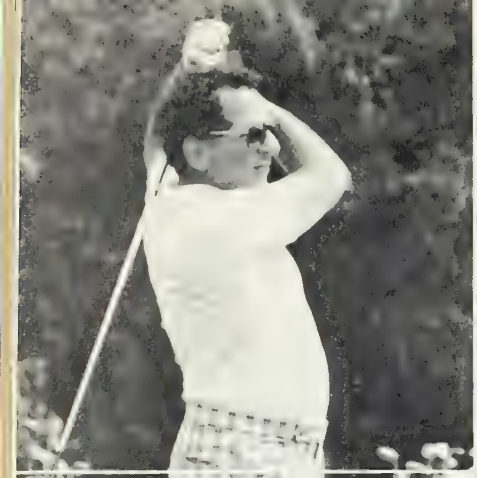
Swimming: 400 Meters
Under 35 Age Bracket
Carlos T. Mock, M.D., Glen Ellyn (5:14.1)
36-45 Age Bracket
Craig Dean, M.D., Libertyville (7:09.3)
46-55 Age Bracket
Barry Seiller, M.D., Lake Forest (9:51)
56-65 Age Bracket
Fred Z. White, M.D., Chillicothe (9:29.8)
Alfred D. Klinger, M.D., Bedford Park (10:29.3)

Golf Tournament
Closest to Hole (#9): J.M. Ingalls, M.D., Paris
Closest to Hole (#12): Arcadio F. Ortiz, M.D., Lake Forest
Longest Drive (#4): Arcadio F. Ortiz, M.D., Lake Forest
36-45 Age Bracket
Low Gross: Holly Steiner, Barrington (93)
Low Net: Marvin R. Fetter, M.D., Lake Forest (74)
46-55 Age Bracket
Low Gross: J.M. Ingalls, M.D., Paris (81)
Low Net: Victor Steiner, M.D., Barrington (72)
56-65 Age Bracket
Low Gross: William J. Marshall, Jr., M.D., Olympia Fields (89)
Low Net: William J. Marshall, Jr., M.D., Olympia Fields (75)

Racquetball Tournaments
Men's Tournament
1st: Sankara R. Peruri, M.D., Libertyville
2nd: Richard L. Carson, M.D., Herrin
3rd: Nelson Borelli, M.D., Chicago
4th: Alfred J. Clementi, M.D., Arlington Heights
5th: Irwin F. Willinger, M.D., Chicago
Women's Tournament
1st: Fusan Borelli, Chicago
2nd: Mary Clemency, M.D., Wilmette
3rd: Lonny Meyers, M.D., Chicago
4th: Mary Beth Carson, R.N., Herrin

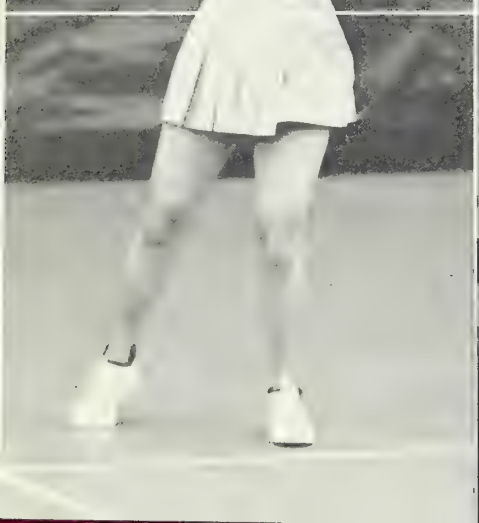
Tennis Tournaments
Mixed Doubles Tournament
1st: B.U. Chung, M.D./Myung Chung, Barrington
2nd: Araceli T. Hankins, M.D./John M. Prabhakar, M.D., Lake Forest & Rochelle
3rd: Zita B. Yorro, M.D./E.A. Doisy, M.D., Waukegan & Granite City
Men's Singles—Friday Tournament
1st: William J. Marshall, Jr., M.D., Olympia Fields
2nd: Henry J. Dold, M.D., Arlington Heights
3rd: William D. Reinwein, M.D., Moline
Men's Singles—Saturday Tournaments
36-45 Age Bracket
1st: E.A. Doisy, M.D., Granite City
2nd: Lofton Kennedy, M.D., Chicago
3rd: Frank Apantaku, M.D., Chicago
46-55 Age Bracket
1st: B.U. Chung, M.D., Barrington
2nd: Joseph Murphy, M.D., Chicago
3rd: Hung-Shing Tsang, M.D., Aurora
Women's Singles
36-45 Age Bracket
1st: Araceli Hankins, M.D., Lake Forest
2nd: Anita Avila, M.D., Lake Forest
3rd: Zita Yorro, M.D., Waukegan
46-55 Age Bracket
1st: Myung Chung, Barrington
2nd: Lonny Meyers, M.D., Chicago
3rd: Patricia Tsang, Aurora

Karate Demonstration
David A. Anzaldua, M.D., Peoria
Stuart Kortebein, M.D., Arlington Heights
Edward Winslow, M.D., Wilmette

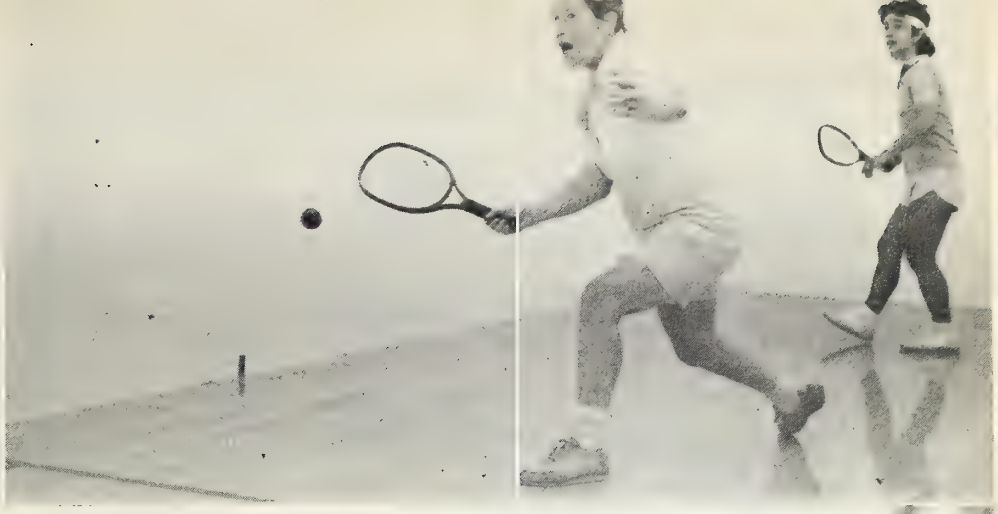








THE WHITE HOUSE

WASHINGTON

Santa Barbara

August 15, 1985

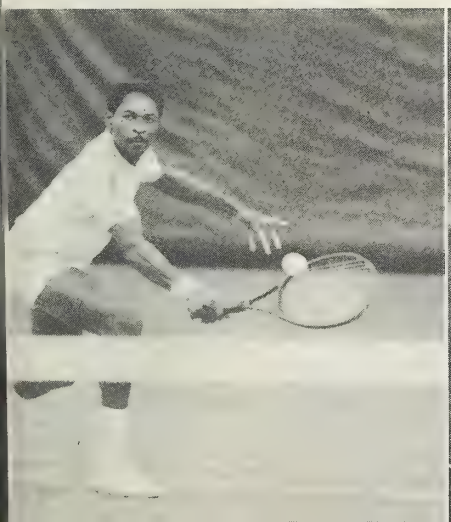
I am pleased to send warm greetings to all those gathered for the first Illinois State Physicians Games in Lincolnshire, Illinois.

As in any civilized society, the physician plays a vital role in America. We look to our doctors not only for medical advice but for counseling on how to lead healthy, rich and fulfilling lives. It is so important that those who are responsible for the treatment and prevention of maladies in others should maintain their own bodies through diet, exercise and good habits.

Your games are an inspiration not only to the medical community but to all Americans. They give us all the more confidence in those we rely on to set the best example in health care and in daily living. I commend all those doctors participating and send my best wishes for this event and for the future of the Illinois State Physicians Games.

Ronald Reagan







DOCTOR'S NEWS

McLEAN COUNTY HONORS LEGISLATORS

The McLean County Medical Society and Auxiliary recently honored two local legislators for their help in passing malpractice reform legislation. Sen. John Maitland (R-Bloomington) and Rep. Gordon Ropp (R-Bloomington) were the guests of honor at a local reception which was well attended by area physicians and their spouses. The Illinois State Medical Society is encouraging other county societies to conduct similar events to establish rapport with their legislators.

PHYSICIANS IN THE NEWS

Dr. Leo P.A. Sweeney, a retired ophthalmologist from Evergreen Park, has been elected president-elect of the Fifty Year Club of American Medicine. Dr. Sweeney is a past president of the Illinois State Medical Society. Founded in 1960, the Fifty Year Club has a membership of more than 1,900. Physicians who graduated from medical school at least 50 years ago are eligible for membership.

Gregory White, M.D., River Forest, has assumed the presidency of the medical staff of Loretto Hospital, Chicago. Dr. White serves in the hospital's department of family and general practice and is a graduate of the Loyola University Stritch School of Medicine.

The American College of Physicians has announced that **Dr. Harold A. Kessler,** Northbrook, has been elected to fellowship. A graduate of Rush Medical College, Dr. Kessler is senior attending assistant professor of medicine and immunology/microbiology at Rush-Presbyterian-St. Luke's Medical Center.

Another Northbrook physician, **Dr. Edward E. Gordon,** recently received the 1985 Recognition Award for Distinguished Clinicians of the American Academy of Physical Medicine and Rehabilitation. A graduate of Tufts College Medical School, Dr. Gordon is medical director of the Westlake Community Hospital Center for Rehabilitation in Melrose Park.

Three Illinois physicians recently were honored with fellowship in the American College of Radiology. The physicians, **Drs. Patrick F. Mahon,** Springfield; **Richard Gardiner,** Hinsdale; and **Ki E. Chung,** Chicago, were honored in a ceremony at the September annual meeting of the college in Montreal.

ANTIDOTE FOR MALPRACTICE LITIGATION

Miscommunication between physician and patient, unclear medical records, faulty office staff procedures, and numerous other potential mishaps can lead to malpractice litigation. How to prevent the causes and their resulting lawsuits is the purpose of the Illinois State Medical Society's *Antidote* newsletter, now in its third year of publication.

Published six times a year, *Antidote* examines actual medical malpractice cases, extracting lessons from their circumstances. Its aim is to help physicians recognize the common causes of claims with high damage potential. Doctors can then tailor their medical practices to avoid such risks.

Antidote is a practical tool and not intended to provide legal advice on medical malpractice litigation. It analyzes medical practices and human relations issues which can lead physicians into the courtroom. It highlights jurors' perspectives on what facts are important in reaching verdicts. And it takes a broad view of how malpractice cases develop in the eyes of plaintiffs, defendants, and others involved in litigation.

Many physicians circulate *Antidote* regularly among office and related medical staff to raise awareness and sensitivity to the malpractice climate. All ISMS members and policyholders of the Illinois State Medical Inter-Insurance Exchange receive a free subscription. If you have not seen *Antidote* or know of someone who would like to be added to the mailing list, please contact ISMS at (312) 782-1654. ◂

AMA HOSPITAL MEDICAL STAFF SECTION TO MEET

The sixth annual assembly of the American Medical Association's Hospital Medical Staff Section will be held December 5-9, at the Shoreham Hotel, Washington, D.C. The AMA is encouraging all physicians and medical staff representatives to participate in the meeting and "visualize the future of American medicine within the next five years." The theme of the Assembly is "Physicians in the 90s."

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MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

A total of 178 families with one or more children with insulin-dependent diabetes were followed for seven years to ascertain characteristics suggesting increased risk toward diabetes. Of 351 nondiabetic children, ten developed diabetes. Eight were HLA identical to their diabetic proband, 9 had HLA-DR3 and/or HLA-DR4. Islet cell surface antibodies and islet cell cytoplasmic antibody were found from 2-74 months prior to clinical diabetes onset. A decreased insulin secretion was noted in all children, even those with normal glucose levels. The triad of HLA identity, pancreatic islet cell antibodies, and a depressed insulin secretion could identify high risks for developing insulin dependent diabetes mellitus. (Ginsberg-Fellner, F., *et al.: JAMA* 254#11:1469-72, Sept 20, 1985)

Infants with birthweight of 1500gm or less are at high risk for neonatal death, sensory handicap, cerebral palsy and a high per capita cost for care. The leading predictors of very low birth weight were low weight of last live birth, fetal malformation, nonwhite race, early vaginal bleeding, cigarette smoking, and chorionitis. Only prolonged rupture of membranes, chorionitis, and congenital malformations contributed to the risk of cerebral palsy. (Nelson, K., Ellenberg, J: *JAMA* 254#11:1473-79, Sept. 20, 1985)

The FDA suggests greater caution in the use of theophylline in infants less than one year of age. Serious toxicities are possible because of the altered hepatic microsomal enzymes, variations in the renal clearance or other factors. The FDA suggests the following dosage if theophylline is necessary: term infants to 4 weeks postnatal 1-2 mg/kg each 12 hrs, at 4-8 weeks each 8 hrs, and beyond 8 weeks 1-3 mg/kg each 6 hrs. (*FDA Drug Bulletin* 15#2:16-7, Aug. 1985)

Thirty-five patients were evaluated for multiple sclerosis on the basis of criteria formulated by McAlpine, *et al.* Magnetic resonance imaging, cerebrospinal fluid analysis, evoked potential testing and computed tomography were employed. The MRI showed lesions in the white matter of the cerebri, particularly in the periventricular regions. The cerebellar white matter correlated with the CT scan, not with the duration of MS, nor the disability, the CSF oligoclonal banding. The MRI accurately assessed the brain stem lesions in 15 cases not observed on the CT scan. (Kirshner, H. *et al.: Arch Neurol* 42#9:859-63, Sept. 1985)

A retrospective study on 159 patients with internal carotid occlusion or stenosis showed a high incidence of smoking, vascular claudication, obesity, family history of cerebrovascular disease, and ischemic changes on ECG. The mean values of systolic and diastolic pressures were higher in the patients with internal carotid artery obstruction than in the control cases and the plasma glucose levels were similarly more elevated than in the controls. No distinct association could be made as to triglyceride levels or cholesterol levels and incidence of stenosis or obstruction. (Bogousslavsky, J. *et al.: Arch Neurol* 42#9:864-67, Sept. 1985)

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ISMSA: Working For Illinois Medicine

By Jean Cavanaugh, Great Bend, Kansas/AMAA North Central Regional Vice President

A hearty greeting to all the Illinois physicians, and a special thank you to the ISMSA President Suzanne Meirink for the golden opportunity to communicate with you.

In today's medical world, physicians are faced with a physician glut, DRGs, competitive medical advertising, increased malpractice insurance costs, lawsuits, complaining and unhappy patients, and demanding consumers. Now is the time for all physicians and their spouses to work together as a team, and present a forceful, vigorous, and caring medical image to the public. It seems that physicians are criticized at the "drop of a hat." Community involvement can bring better understanding. While most physicians do not have extra time to become totally involved in their communities and cities, spouses can often find time to become active community volunteers.

During the national AMAA Convention in Chicago this June, Illinois delegates were spotted wearing circular three-inch pins which stated, "Medical Auxiliary Volunteer," and in the center of a red heart were three important words, "DOCTORS' WIVES CARE." The pins sold for $1.00, and were snapped up by auxiliary members from across the country. I was so impressed that I ordered them for my own county auxiliary members. When community people see an auxiliary volunteer wearing this pin they know that this individual is working to make the community a better place for others. It's important that physicians support their spouses in their volunteer work, and especially auxiliary health projects. Your spouse can be your best public relations promoter.

The ISMSA and the AMAA need your support and your spouse's membership dues. If he/she does not elect to be a working member, please pay his/her dues so that he/she is a supportive member. Nationally, we are an 80,000 member group, and each member's dues help to further our health-oriented educational programs from the very small communities to our largest cities. The auxiliary needs your spouse's membership for a viable and visible organization.

The ISMSA works in four main areas: membership, legislation, AMA Educational Research Foundation, and health projects. The spouses are available to assist you in your legislative efforts.

I recall reading about your successful society and auxiliary lobbying day this past spring when your state legislature was voting on your medical future. Your spouse may write your legislative letters, make contacts with your legislators, and appear when necessary at rallies to promote health related issues.

Our medical school deans cannot function without AMA-ERF dollars. When asked to contribute or to donate to a county function, think of your gift as a thank you to your medical school for the opportunity to practice medicine and to help others enjoy a healthier life. Support your auxiliary's health projects, which may range from a child care sitter's course and pre-school screening, to programs on teenage suicide and new innovative projects for the older generation.

Please check with your spouse and see if his/her dues are paid for this year. Encourage him/her to join the local auxiliary. If your county medical society does not have an organized auxiliary, do send a $30.00 check for state and national dues to the ISMSA treasurer, Carole Taylor, 274 Oakley Place, East Alton, IL 62024.

Join with your spouse to improve the physician's image and work together for better medical public relations and communication with the public. ISMSA President Suzanne Meirink and her state board need and deserve your support.

Abstracts of Board Actions

(Continued from page 308)

HB 1947–MEDICAL DETERMINATION BOARD

On September 25, 1985, Governor Thompson exercised an amendatory veto of House Bill 1947. This was a proposal the Society had amended to recreate the Medical Determinations Board. Existing law states that the Board reviews IDPH rules and regulations except those for the Hospital Licensing Board and the Ambulatory Surgical Treatment Center Board. As a result of the veto the exclusion for rules for the Ambulatory Surgical Treatment Center Board and the Hospital Licensing Board are reinserted.

The Board agreed to accept the Governor's Amendatory Veto of HB 1947 and not attempt to override unless legislative circumstances change.

GRADUATE MEDICAL EDUCATION FUNDING

The current system of financing much of graduate medical education (GME) through Medicare funding is being challenged by not only the administration but also members of the Congress through proposed legislation. A set of guidelines has been developed which can be used to analyze funding strategies for GME. These guidelines could form the basis of a position statement for ISMS regarding this complex issue. (The guidelines are reproduced below.)

The Board approved Guidelines for Evaluating Funding Proposals Affecting Graduate Medical Education consistent with the AMA's Health Policy Agenda. The Board also: (A) Agreed to oppose all current bills that would change the current method of providing federal funding for graduate medical education; and (B) Reaffirmed a position that the current system of using Medicare Funds to help finance graduate medical education should be continued as a means of subsidizing graduate medical education, until a better system is developed.

COMMITTEE ON DRUGS AND THERAPEUTICS

The Board approved the following drug products for inclusion in the IDPA Drug Manual: Sectral (acebutolol HCL) 200mg, 400mg caps.; Desyrel (trazedone HCL) 150mg Dividose Tab.; Didronel (etidronate sodium) 400mg tab.; and Halcion (triazolam) 0.125mg Tab.

The Board also recommended that the following drugs not be included in the IDPA Drug Manual: Merital (nomifensine) 50mg. Caps.; Alupent (metaproterenol sulfate) 0.6% Inhalant; Buprenex (buprenorphine HCL) 0.3mg/ml INJ, 1 ml Ampules; Lopressor HCT (metroprolol tartrate, hydrochlorothiazide); Nuprin (ibuprofen) 200mg. Tab.; Trandate (labetalol HCL) 100mg Tabs.; Normodyne (labetalol HCL) 100 mg Tabs.; Cytoxan (cyclophosphamide) Compliance Pak Tabs.; and Pilopine (pilocarpine HCL) H.S. Gel 4%.

The Board further recommended that the following drug products previously available only through the prior approval process now be included in the IDPA Drug Program: Levothyroxine tablet 0.075mg, 0.125mg; Doxepin capsule 10mg; Imipramine tablet 10mg; Suby's G Irrigation Solution; Beclomethasone Nasal Inhaler; Heparin; Sodium Polystyrene Sulfonate Suspension; and Ergonovine Maleate tablet 0.2mg.

In addition, the Board reconsidered the drug products Tornalate and Tenoretic and recommended that Tornalate be included in the IDPA Drug Manual, and reaffirmed previous Committee action to not include the drug product Tenoretic in the IDPA Drug Manual.

GUIDELINES FOR EVALUATING FUNDING PROPOSALS AFFECTING GRADUATE MEDICAL EDUCATION

1. Programs of graduate education for physicians in training are essential, and continued excellence in graduate medical education requires long-term, adequate financial support.
2. The current system of using Medicare funds to help finance graduate medical education should be continued as a means of subsidizing graduate medical education until a better federal system is implemented.
3. Financial support of graduate medical education should be shared by the public sector, the private sector, and physicians in training.
4. Federal, state, and local groups representing private and public interests involved in the funding of graduate medical education should come together to consider a long-range strategy to deal with the situation in an effective and coordinated manner.
5. Faculty supervision in graduate medical education programs for physicians in training should assure effective patient care and patient safety while providing increasing supervised responsibility for patient care.
6. Graduate medical education should be directed toward preparing practitioners in all of the specialties of medical practice, educators, and research scientists.
7. Payments are justified to those enrolled or otherwise participating in graduate medical education.
8. The possibility of a federal or state level trust fund should be explored to test its viability in distributing subsidies for graduate medical education.
9. The activities and proposals originating from the AMA's Health Policy Agenda should be monitored on an ongoing basis to determine their applicability to the needs of Illinois graduate medical education programs and the interests of ISMS.

POLICY COMMITTEE

Upon recommendation of the Policy Committee, based upon actions taken by the House of Delegates at its 1985 annual meeting, the Board approved the following policy statements for inclusion in the Policy Manual (Language will be reflected in the 1985 Policy Manual):

New Policies

- Insanity as a Defense (20 A-84)
- Membership Dues Stabilization (9 A-85)
- Discrimination Against Physicians (23 A-85)
- Impaired Physicians (27 A-85)
- Athletic Performance, Inappropriate Use of Procedures to Improve (11 A-85)

Amended Policies

- Blood Availability (2A-85)
- Surgery, Reconstructive (3 A-85)
- Advertising Guidelines, Physician Professional (5A-85)
- Continuing Education (32 A-85)
- Reimbursement, Physician (1 A-85)
- Hospital Medical Staff Privileges (14 A-85)
- Laboratories (15 A-85)
- Hospital—Medical Staff—Management Relationship (20 A-85)
- Smoking (4 A-85)

The Board also agreed to the following:

- Hospital Medical Staff Privileges (14 A-85)
 To make an editorial change in the last sentence of this policy which now reads, "A physician's hospital privileges should be based on clinical competency and quality of care."
- PPO Terminology (10 A-85)
 To restudy Res. 10 for the purpose of using the term "contract provider" parenthetically, and not to publish a statement on PPO terminology in the ISMS Policy Manual at this time, pending further review.

In addition, the Board directed that: (A) Hospital medical staffs be informed of policy changes affecting hospital medical staff; and (B) Bylaws be reviewed to identify any possible conflicting analyses of policy.

OTHER ACTIONS

In addressing various other issues, the Board:

- Accepted: The Financial Statements for the period ended June 30, 1985; August 31, 1985 IMPAC Collection Data Report; August 31, 1985 dues Payment Report; August 31, 1985 Dues Payment Report; and Requests for Changes in Membership Status.
- Ratified the program schedule and budget for the November 2-3, 1985, All-Member Conference, to be held at the Peoria Continental Regency Hotel.
- Authorized submission of an Illinois resolution to the AMA entitled, "Introduction of Section Resolutions," regarding late resolutions to the AMA.
- Agreed to: (A) Explore the possibility of co-sponsoring with the Chicago Medical Society the Chicago Medical Society's Member Insurance Programs; (B) Review, revise, and study incorporation of financial planning in the current Illinois State Medical Society member insurance programs for those counties other than Cook; (C) Appoint a permanent committee of the Board to implement these recommendations; and (D) Discharge the Task Force on Member Insurance Programs.
- Agreed to hold the November 7-9, 1986, meeting of ISMS at the Ramada Hotel, Mount Vernon, Illinois.
- Agreed to hold the 1987 Annual Meeting, April 8-12, 1987, at the Westin-O'Hare Hotel, Rosemont.
- Ratified the distribution of a letter to all members informing them of the October 1 date by which a decision must be made regarding Medicare Part B participation.
- Agreed to oppose pending Federal Tax Reform Legislation requiring an accrual method of accounting for service corporations.
- Effected no changes in the 1986 *IMJ* subscription rates.
- Approved for publication amendments to the Constitution and Bylaws on the following, as adopted by the House of Delegates: Membership, Dues and Assessments, County Societies, House of Delegates, and Committees.
- Agreed to urge the AMA to continue to oppose the freeze on Medicare fees and to take appropriate measures to ensure that adequate time parameters are established for physicians to make informed decisions on participation in Part-B Medicare.
- Agreed to urge the AMA to meet with HCFA representatives in an effort to standardize the common claim reporting criteria for all governmental health care reimbursement programs.
- Agreed to establish a central roster of physicians approved by the Chairman of the Board who have indicated a willingness to serve on or as a consultant to the Illinois Department of Public Aid.
- Agreed to adopt and implement the AMA Prescription Abuse Data Synthesis program for use in Illinois.
- Approved various legislative positions with respect to primary bills.
- Directed that the Councils on Education and Manpower and Medical–Legal study the problem of medical school curriculum in regard to education on medical-legal aspects of medical practice.
- Agreed to hold the Telephone Retention Program (targeted to ISMS members who have not paid their dues) on an annual basis, and that the retention activities be enlarged to include ISMS Delegates and Alternate Delegates.
- Agreed to Encourage Action Teams to stay active in organized medicine's activities at both the county

and state levels and to specifically encourage Action Teams to promote membership.

- Agreed to ask ISMIS to include a Physician Support Group brochure in ISMIS materials sent to physicians under litigation. The Physician Support Group is designed to help physicians cope with their personal reactions to being sued.
- Authorized that: (1) $100,000 be released from the Illinois State Medical Society student loan fund account for the purpose of providing student loans to eight Illinois medical schools for academic year 1985-86 in the following increments: Univ. of Chicago, $12,540; Loyola Univ. $9,250; Rush Medical College, $12,820; Chicago College of Osteopathic Medicine, $9,700; Northwestern Univ. Medical School, $17,360; Univ. of Illinois, $15,180; Southern Illinois Univ., $5,840; and Chicago Medical School, $17,310; and (2) Interest rates be set for the above loans at 5.5% to allow for basic administrative costs of the program.
- Agreed that a central repository was needed for educational ISMS videotapes, and directed that a videotape library be established for dissemination of videotapes for use by other groups.
- Directed that the Council on Public Relations and Membership Services consider the policy relative to a special class of membership with some reduction of dues for physicians employed at the University of Illinois Student Health Service.
- Directed that the Council on Education and Manpower review a request from the IDPH Family Practice Residency Act Advisory Committee of the need to change the payback arrangement for service commitment in exchange for scholarship support, from three years to four years and, secondly, in the interest of conformity, to include OB-GYN as a primary care specialty under the Residency Program.
- Referred to the Executive Committee a request for establishment of a Section on Medical Schools with a seat in the House of Delegates.
- Referred to the Executive Committee a question regarding current requirements by IDPH for a TB Tine Test for all persons in nursing homes.

PROGRAMS/SPONSORSHIP

The Board:

- Agreed to co-sponsor the 1986 AMA National Conference on the Impaired Physician. (At no cost to ISMS)
- Approved a request that Debra Klamen, M.D., attend the University of Illinois Conference on Stress, Impairment and the Resident, October 24-26, and that her registration fee be paid from RPS funds.

NOMINATIONS AND APPOINTMENTS

Various appointments and nominations were approved or ratified by the Board, as follows:

- Nominated Dr. Phillip Forman, Chicago, to the IDPH Family Practice Residency Program.
- Ratified the following nominations:
 Dr. Lawrence L. Hirsch, ICCME 1986 Nominating Committee.
 Dr. Pedro A. Poma, IDPH Study Committee on Infant Mortality.
 Dr. Stewart Spies, Radiologic Technology Accreditation Board.
 Dr. William Schultz, Title X Family Planning Advisory Board.
 Dr. Alfonse Masi, Drug Product Selection Committee.
 Dr. Terry Mason, Governmental Affairs Council.
 Dr. David Lewis, Medical Legal Council.
 Dr. Sam Gaines, Committee on Alcoholism and Drug Dependence.
 Dr. Alfred J. Kiessel, Third Party Payment Processes Committee.
 Dr. Ronald G. Welch, Building & Capital Equipment Committee.
 Drs. Ronald G. Welch, Chairman, Audley F. Connor, Jr., Harold L. Jensen and Fred Z. White, IDPA HMO Contract Review Panel.
 Drs. Noel Bass and Audley F. Connor, Jr., Medical Determinations Board.
 Drs. Alfred J. Clementi, David S. Fox, Harold L. Jensen, Morgan M. Meyer, and Rischer Watts, Task Force on Discipline.
- Nominations for Resident Representatives to various councils.

OTHER MATTERS

The Board reviewed the following reports from the Executive Committee:

PPO LAW (SB 1311)

ISMS recommended to the Governor that he veto this legislation. The bill specifically permits an insurer to issue or administer contracts for the provision of health care services, including agreements as to the amounts covered for insureds or beneficiaries for such services.

In considering legal counsel recommendations, the Executive Committee has deferred any specific action on the PPO law at this time.

TASK FORCE ON DISCIPLINE

In keeping with previous Board action and as endorsed by the Governor, the Task Force on Medical Discipline has been established. The function of the Task Force is twofold: (1) Identify candidates for the position of Medical Coordinator in the Department of Registration and Education; (2) Review the discipline process. The Task Force will meet initially to review potential candidates and the position description. Following completion of this, a review of the disciplinary process itself will be accomplished for the purpose of recommending additional rules or legislation to improve this function of government.

Any physician having knowledge of specific problems with the disciplinary process has been invited to submit case studies for consideration by the Task Force.

INSURANCE

In addition, the Board heard reports from: (A) ISMIS on current activities under policies established by ISMIS, and (B) ISMIE on policy change considerations which would be before the ISMIE Board of Governors.

INFORMATIONAL REPORTS

Informational reports were presented by the Council on Mental Health and Addiction, Committee on CME Accreditation, ICCME, IL-HMSS, Auxiliary, IMPAC, Medical Student Section and AMA Delegation Chairman.

NEXT MEETING

The next Board of Trustees meeting was set for November 1-3, 1985, at the Peoria Continental Regency Hotel.

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FACULTY

T. H. Alt, M.D.
E. C. Gay, Jr., M.D.
L. A. Lewis, M.D.
G. D. Monheit, M.D.
O. T. Norwood, M.D.
D. Orentreich, M.D.
D. B. Stough, III, M.D.
W. P. Unger, M.D.
R. C. Webster, M.D.
M. R. Wright, PhD
W. K. Wright, M.D.



Emphasis will be placed on a live surgical work shop for participants with minimal experience.

Viewbox

(Continued from page 313)

Diagnosis: Villous Tumor

All of the choices given could cause sigmoid lesions but the lace-like or reticular pattern of barium coating the lesion makes villous tumor the best choice.

Neoplastic colonic polyps, particularly villous tumors, have been the focus of much attention. Villous tumors occur throughout the G.I. tract but are most frequent in the large bowel. They account for 1.5-2.5% of all colonic neoplasms.[1] It was previously thought that adenomatous polyps and villous adenomas were entirely separate entities, but they are now considered to be histologic variants of the same neoplastic process.[2] In one series, 1242 adenomas and invasive carcinomas from 657 patients were studied, and 2.9% of these were villous tumors.[3]

Pathology

Polypoid neoplasms may be divided into three groups according to their histology: (1) Tubular—more than 80% of the glandular elements are tubular; (2) Villous—more than 80% of the glandular elements are villous or papillomatous and (3) If neither cell type is 80%, mixed or tubulovillous.

The tubular pattern is that seen in what were previously described as adenomatous polyps, where tubular glands are parallel to the muscularis mucosa.

The villous pattern is produced by villi with slender fibrovascular cores covered by surface epithelium. The surface mucosa in these lesions can be thrown into multiple small papillary projections perpendicular to the muscularis mucosa.

Villous tumors can be sessile or pedunculated and occur in three patterns: (1) A flat sessile 'fern-like' pattern with extensive longitudinal and circumferential spread; (2) a soft bulky lobulated mass, with or without a pedicle or (3) a combination of (1) and (2).

Three characteristics of neoplastic polyps are related to malignant potential: size, histologic type and cytological atypia. Muto, *et al.,* found the following relationship between size and the incidence of malignancy: diameter less than 1cm-1%, 1cm-10%, more than 2cm-50%.[2]

Malignancy is more common with villous than tubular histology. In Muto's series, 40% of villous tumors had malignant foci, while only 22.5% of tubulovillous and 4.8% of tubular tumors had malignant foci.[2] Those tumors greater than 10mm with a pronounced villous component had the highest incidence of malignant foci.[4] In addition, as the tumor becomes more villous, severe dysplasia becomes more common.

The degree of cytological atypia is a significant histologic marker. This is especially so with severe dysplasia. Morson has suggested that it would be advantageous to think in terms of a "dysplasia-carcinoma sequence" pattern than the more well known "adenoma-carcinoma sequence."[4] He has shown that severe dysplasia correlates with development of carcinoma better than the type of cells composing the polyp.



Figure 2

Gross pathological specimen showing a villous tumor of the rectum illustrating the multiple small papillary projections. It is these projections which, when covered with barium, give the "mousse de savon" appearance.

Malignant change can be difficult to recognize. Several reports have shown a high incidence of false negative preoperative biopsy reports. Taylor, *et al.,*[5] reported 34% and Jahadi[6] reported 40% false negative reports. These preoperative biopsies were done endoscopically and in Jahadi's series included frozen section biopsy. Some but not all of these false negative reports can be explained by differing histologic criteria. Definitive treatment should be based on the histologic diagnosis of the excised polyp following polypectomy or submucosal excision.

Villous tumors have been found to be associated with other malignant processes. One series reported additional malignancies in 22.9%.[1] Most of these were gastrointestinal tumors. Some, however, were found to have malignancies of the breast and lung, for example. Wheat and Ackerman found 32% of their series had associated neoplasms either benign or malignant.[7] Another series found 50% had additional neoplasms diagnosed on barium enema.[8] The importance of these

findings is that the detection of any rectal or colonic neoplasm, especially a villous tumor, should be followed by examination of the whole large bowel in search of an associated carcinoma or other neoplasm.

Villous changes have been found in patients with long standing ulcerative colitis. Rubrio, *et al.*,[10] found villous changes with or without dysplasia to be common among these patients. It is well known that there is an association between severe dysplasia and invasive adenocarcinoma in these patients. Rubrio, *et al.*, suggest that villous changes are an ominous sign and constitute an indication for colectomy.

Clinical Presentation

Villous tumors may be asymptomatic or have features similar to other tumors of the colon. The commonest symptom is red rectal bleeding. Others include melena, altered bowel habit, abdominal pain and weight loss. The "classical" symptomatology of watery diarrhea and hypokalemia has been found to occur in only 5.7% of patients.[1]

Radiologic Appearance

The typical radiographic appearance of a villous tumor was described by Walk in 1951. He referred to the "mousse de savon" or soap bubble effect. This consists of multiple radiolucent areas interspersed in a fine or coarse lace work appearance of barium, caused by barium collecting in the clefts between the fronds of the tumor. Post evacuation films may best show the barium remaining in the clefts after mucous has been squeezed out.

In 1960, Wolf emphasized change in shape and size of villous tumors due to their pliability and softness. Malignant change can be suggested on barium study though there are no reliable indicators. Features suggesting malignancy include fixation, luminal narrowing, loss of adjacent haustral markings, ulceration and basal indentation.

Two pitfalls may result in missing a villous tumor. When the tumor is "carpet-like" and extensive it may be mistaken for retained stool. Secondly, poor mucosal coating with barium due to mucous production by the tumor may result in poor definition of the lesion.

Management and Prognosis

The management of these tumors depends on accurate histologic diagnosis, size, and location of the tumor along with the general condition of the patient. In general, larger lesions above the rectum are removed by segmental resection. Small or pedunculated lesions can be removed by polypectomy and then subsequent histology will dictate further management.[11]

Rectal lesions which are benign can be managed by local excision. Invasive carcinoma in a villous tumor is treated by radical excision or abdominal perineal resection.

The incidence of local recurrence of tumors of the colon was found to be less than that of rectal lesions. Most local recurrences occurred in patients whose tumors were initially treated by local excision. When local recurrence occurs after removal of a benign lesion, 83% recur as benign lesions.[6]

The overall five year survival rate with malignant villous tumor is somewhat better than with adenocarcinoma.[6,11]

It is recommended that all patients with previously excised benign villous tumors have annual follow-up examinations with colonoscopy or double contrast barium enemas. ◀

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6. Jahadi, M.R., Baldwin, A.: "Villous Adenomas of the Colon and Rectum," *Am J Surg* 130:729-732, 1975.
7. Wheat, M.W., Ackerman, L.V.: "Villous Adenomas of the Large Intestine," *Ann Surg* 147:476-487, 1958.
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10. Rubio, C.A., Johansson, C., Slezak, P., Ohman, C.U., Hammarberg, C.: "Villous Dysplasia. An Ominous Histological Sign in Colitic Patients," *Dis Colon Rectum* 27:283-287, 1984.
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PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

ALTON:
Population 38,000. Opening a new multimodality diagnostic and treatment center in December, 1985. State-of-the-art equipment includes magnetic resonance, computed tomography, linear accelerator, extensive cardiac studies equipment, chemotherapy facilities, as well as several suites available for private practice physicians. We also plan to have a walk-in outpatient clinic, outpatient surgical center, and pharmacy within the clinic. We are especially interested in physicians practicing in neurology, internal medicine, oncology, orthopedics, pediatrics, cardiology, pathology, urology, gastroenterology, radiation therapy, general surgery, OB/GYN surgery, family practice, and neurosurgery. Available immediately. Contact: Bruce Vest, M.D. or Kimberly Eizember, Doctors Clinic, P.O. Box 617, Alton 62002, (618) 474-7850. (1)

BLOOMINGTON:
Internal Medicine—To join an active six member IM practice in mid-western university community. A sub-specialty in rheumatology, endocrinology, or allergy is desirable, but not necessary. Contact: J. Buchanan, The Health Center, 702 N. East St., Bloomington 61701 (309) 827-5051. (9)

CARBONDALE:
Multi-specialty group needs the following physicians—allergist, pulmonologist, otolaryngologist and orthopedist. Contact: Wayne Given, 2601 West Main Street, Carbondale 62901, (618) 549-5361. (12)

GLEN ELLYN:
Full or part-time radiologist—Position in 60-physician, multispecialty, outpatient facility for radiologist. Facilities include flouroscopy, tomography, mammography, diagnostic ultrasound, plus general radiology. Salaried position with excellent fringes, excellent workload and hours in comparison with hospital setting, plus the ability to work with a quality leading group in a pleasant suburban environment. Send CV to: Glen Ellyn Clinic, 454 Pennsylvania Avenue, Glen Ellyn 60137.

GRAYVILLE:
On Interstate 64; Population 3,000; 65,000 medical market area. Modern, completely furnished medical-dental clinic facility, 20-minutes from two modern hospitals. Steady economy—oil, light manufacturing, coal mining, power generating, agriculture and service industries. Contact: C.W. Wilson, 610 North Court Street, Grayville 62844, (618) 375-6341. (1)

LINCOLN:
Population 18,000. Serving a county-wide area of 40,000. Located on Interstate 55, 200 miles south of Chicago and 100 miles north of St. Louis. Average 30 miles from Springfield, Decatur, Peoria and Bloomington. Medical group looking for OB/GYN, orthopaedics, family practice and emergency physicians. Contact: Mary Richter, Abraham Lincoln Medical Group, S.C., 311 8th Street, Lincoln 62656. (1)

MONMOUTH:
Internist or family practitioner to join a practice in a small town. Terms negotiable. Please send curriculum to P.O. Box 183, Monmouth 61462. (12)

What is a Medical Assistant?

By Catherine M. Hill, CMA/Palatine

The medical assistant is the link between patients, family members, and the physician. They are trained administratively and clinically to perform a wide variety of duties in the office. The primary function of the medical assistant is to assist the physician in seeing that the day-to-day function of the office is run efficiently. Also, under the physician's supervision, the medical assistant can relieve the physician of many duties and give the doctor more time to direct his/her attention to the patient's diagnosis and treatment. The medical assistant learns how to handle patients and situations in the physician's absence. The functions performed by the medical assistant in an ordinary day are both administrative and clinical.

Administrative

The medical assistant will:

- effectively schedule appointments;
- maintain patient files, including all medical records
- handle all incoming and outgoing mail
- complete all types of insurance forms and maintain financial records and
- track inventory of medical and office supplies.

Clinical

The medical assistant also:

- takes and records a patient's vital signs;
- obtains and records a complete medical history from new patients;
- per the physician, educates patients about diet and preparation for tests to be performed;
- under a physician's direction, administers medications and
- prepares patient's specimans, (blood, urine, etc.) for transfer to an outside laboratory or for testing in the office laboratory.

These are only a few of the many functions the medical assistant is trained and taught to perform. These skills will vary with each physician's speciality.

In the state of Illinois, the following institutions offer accredited programs. A certificate or diploma program is equivalent to one year upon completion. An associate degree program is equivalent to two years upon completion.

- Belleville Area College
 Belleville, Illinois 62221
 Degrees Granted: Certificate, Associate Degree
- Robert Morris College
 Carthage, Illinois 62321
 Degrees Granted: Certificate, Associate Degree
- William Rainey Harper College
 Palatine, Illinois 60067
 Degree Granted: Associate Degree
- Triton College
 River Grove, Illinois 60171
 Degree Granted: Associate Degree
 (Evening courses to be offered in the Spring semester 1986)

Upon completion of an accredited program, and completion of one year's full-time employment by an M.D. or D.O., or as a medical assisting instructor at a nationally accredited post-secondary institution, the medical assistant is eligible to take the Certified Medical Assistant (CMA) examination, which includes both administrative and clinical subject matter. This examination is endorsed by the American Association of Medical Assistants (AAMA). Upon passing the examination, the medical assistant can place the CMA initials after her name. Successful completion of this examination enables the medical assistant to be nationally recognized as a qualified health professional.

Information regarding the Illinois Society, medical assisting and/or accredited programs can be obtained from Ehlma Garcia, CMA, EMT-A, President, Illinois Society, 6134 South Tripp, Chicago, Illinois, 60629; Robin Bluestein, CMA-C, Co-Chairman, Public Relations Committee, 2247 West Estes, #2, Chicago, Illinois 60645 or Catherine M. Hill, CMA, Co-Chairman, Public Relations Committee, 900 South Plum Grove Road, Palatine, Illinois 60067.

EKG

(Continued from page 326)

Answers: 1. A. C. 2. E.

The ECG has normal PR, QRS, and QT intervals with a QRS axis of approximately +120°, abnormal right axis deviation. The QR pattern in leads V_1 to V_4 suggest severe right ventricular hypertrophy. The initial Q wave here could be due to unusual right septal forces or the transmission of right ventricular intracavitary potentials to the surface leads. The Q wave in lead AVL is more likely related to the right ventricular hypertrophy and right axis deviation than a myocardial infarction.

The pulmonary artery catheter showed a pressure of 120/15mmHg. This had been recorded at a cardiac catheterization performed two years earlier at another institution. At that time, left ventricular function and coronary artery anatomy were normal.

Hemodynamic measurement of the pulmonary artery pressure is diagnostic of primary pulmonary hypertension. There was no evidence now for pulmonary emboli. A nuclear medicine blood flow study was consistent with pulmonary hypertension. M-mode and two dimensional echocardiography can rule out silent mitral stenosis as well as types of congenital heart disease associated with pulmonary hypertension. Anticoagulation is clearly helpful in cases of pulmonary emboli but its use in primary pulmonary hypertension is based on post mortem studies showing clot in large and small pulmonary veins and arteries. The best treatment of pulmonary hypertension is removal of its inciting cause before irreversible pulmonary vasculature damage occurs, *e.g.*, closure of left-to-right shunts. When there is no demonstrable cause, pulmonary vasodilators have been tried: hydralazine, nifedipine, phentolamine, isoproterenol, diazoxide, oxygen, tolazoline, and prostaglandins. Conflicting as well as variable results have been reported with these drugs.

Our patient had failed these measures and was referred for consideration of heart-lung transplantation. Only a few patients have received this treatment. Although pain-free for the rest of the day of admission, she died suddenly that evening and could not be resuscitated. Post mortem examination demonstrated cardiac tamponade and a rupture with dissection of the main pulmonary trunk extending into the proximal left pulmonary artery. ◀

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To assure full consideration applicants should send letter of application; resume; and names, addresses and phone numbers of at least three references by December 1, 1985 to:

Terry F. Hatch, M.D.
Chair, Search Committee for Pediatrics
University of Illinois College of Medicine at Urbana-Champaign
506 S. Mathews, Urbana, IL 61801

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GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

DECEMBER

Cardiology/Family Medicine/Internal Medicine

Third International Symposium on Electrophysiologic Basis for Diagnosis and Management of Cardiac Arrhythmias
For: Physicians, cardiac technologists and nurses. Conference, December 27-30, Orlando, FL. **Sponsors:** University of Wisconsin-Madison, CME; Mount Sinai Medical Center, Milwaukee; American Heart Association; Florida Heart Institute and Continuing Education and Research Foundation. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 19 hrs.; AAFP Elective: 19 hrs.; University of Wisconsin CEU's: 19 hrs and AOA Category 2-D. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Pathology

Symposium on Recent Advances in Clinical Microbiology
For: Pathologists and microbiologists. Symposium, December 9, 7:00 p.m., Drake Hotel, Chicago. **Sponsors:** Chicago Pathology Society and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall Short, M.D., Dept. of Pathology, Loretto Hospital, 645 S. Central Avenue, Chicago, IL 60644.

Critical Care Medicine

1st Annual Joint Indo-American Critical Care Symposium
For: Doctors, advanced nursing. Lectures, December 21-23 in New Delhi, India. December 28-31 in Hyderabad, India, 8:30 a.m.-5:10 p.m. (both locations). **Sponsors:** The Chicago Medical School/The University of Health Sciences, 3333 Green Bay Road, North Chicago, IL 60064; Ashok Paul Memorial Fund; The All India Institute of Medical Sciences, New Delhi, India; and The Osmania Medical College/Osmania University, Hyderabad, India. **Fee:** $250. **Reg. Limit:** None. **Credit:** Category 1: 40 hours. **Contact:** Elizabeth Bruechert. **Phone:** (312) 578-3000, Ext. 604.

Gynecology

Problem Solving in Gynecologic Endocrinology and Infertility
For: Gynecologists. Course, December 6-7, Chicago. **Sponsor:** The University of Chicago, 5841 S. Maryland, Box 139, Chicago, IL 60637. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 10 hours: ACOG: 10 Cognates. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Cardiology

Cardiology Conference
For: Physicians and other medical professionals. Conference, December 6, Springfield, IL. **Sponsor:** Southern Illinois University School of Medicine, Box 3926, Springfield, IL 62708. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 7 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean for CME. **Phone:** (217) 782-7711.

Urology/Radiology/Pathology

Urologic Pathology and Radiology
For: Urologists, pathologists and radiologists. Lecture, December 9-13, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Fee:** $615. **Reg. Limit:** 50. **Credit:** Category 1: 41 hrs. **Contact:** Robert J. Baker, M.D., Dean. **Phone:** Local: (312) 633-2600; in Illinois: (800) 621-4649; outside Illinois: (800) 621-4651.

Emergency Care

Trauma
For: Physicians and emergency care professionals. Symposium, December 5, 3:00-7:00 p.m., Quincy, IL. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield, IL 62708. **Fee:** $25. **Reg. Limit:** None. **Credit:** Category 1: 4 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean for CME. **Phone:** (217) 782-7711.

Advanced Trauma Life Support Provider Course
For: Physicians and emergency care professionals. Course, December 4-5, 8:00 a.m.—5:00 p.m., Springfield, IL. **Sponsor:** Southern Illinois University School of Medicine, P.O. Box 3926, Springfield IL 62708 **Fee:** $350. **Reg. Limit:** 20. **Credit:** Category 1: 16 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean for CME. **Phone:** (217) 782-7711.

Cardiology/Family Medicine/Emergency Medicine

5th Annual Conference on Heart Diseases: Imaging Comes to Cardiology
For: Physicians and other health professionals. Conference, December 6-7, Madison, WI. **Sponsors:** University of Wisconsin-Madison, CME; Wisconsin Medical School; Wisconsin Hospital and Clinics. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 12 hrs.; AAFP Prescribed: 9½ hrs.; University of Wisconsin CEU's: 12 hrs.; AOA Category 2-D: 9½ hrs. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

Oncology

Care of Your Patient with Colorectal Cancer
For: Family practice, internists, surgeons, and RN's. Lecture, December 7, 8:00 a.m.-12:45 p.m., Urbana, IL. **Sponsors:** Carle Clinic Association/Carle Foundation Hospital and University of Illinois College of Medicine at Champaign-Urbana. **Fee:** Physicians-$45.; other health professionals-$35. **Credit:** Category 1: 4 hours; AAFP: 4 hours. **Contact:** Lisa K. Staley. **Phone:** (217) 337-3022.

JANUARY

Allergy

Contact Dermatitis and Atopic Eczema
For: Interested physicians. Lecture, January 20 (6:00 p.m. cocktails and dinner; 8:00 p.m. meeting) Chicago. **Sponsor:** The Illinois Society of Allergy and Clinical Immunology, 800 E. Northwest Hwy., Suite 101, Mt. Prospect, IL 60056. **Fee:** $15. **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** Diane Kubis. **Phone:** (312) 255-1024.

Family Practice

Introductory Course to Osteopathy in the Cranial Field
Course, January 7-11, 8:30 a.m.-6:30 p.m., Chicago O'Hare Marriott Hotel, Chicago, IL. **Sponsors:** Chicago College of Osteopathic Medicine and Sutherland Cranial Teaching Foundation. **Fee:** $675. (send fee to: Sutherland Cranial Teaching Foundation, 1140 W. 8th St., Meridian, Idaho 53642) **Reg. Limit:** 44. **Credit:** Category 1A-AOA: 40 hours. **Contact:** Richard A. Feely, D.O. **Phone:** (312) 266-8565.

Pathology

Joint Meeting with American Association of Clinical Chemists
For: Pathologists and clinical chemists. Symposium, January 13, 7:00 p.m., Drake Hotel, Chicago. **Sponsors:** Chicago Pathology Society and Michael Reese Hospital. **Fee:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall Short, M.D., Dept. of Pathology, Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644.

Surgery

Specialty Review in Thoracic Surgery
For: Thoracic surgeons, general and cardiovascular surgeons. January 6-11. **Sponsor:** Cook County Graduate School of Medicine. **Fee:** $670. **Credit:** Category 1: 47 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Review Course in Neurological Surgery
For: Neurologists, neurosurgeons. Lecture, January 31-February 9. **Sponsor:** Cook County Graduate School of Medicine. **Fee:** $840. **Credit:** Category 1: 105 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Neurology/Emergency Medicine

Medical Seminar at Sea (South Pacific Cruise)
For: Physicians. January 15-29, 1986, Symposium-Cruise. **Sponsor:** Southern Illinois University School of Medicine. **Fee:** $500. **Credit:** Category 1. **Contact:** Charles E. Osborne, Ed.D., Assistant Dean for CME. **Phone:** (217) 782-7711.

OB/GYN

Osteoporosis Symposium
For: Physicians. **Date:** To be determined. **Sponsor:** Southern Illinois University of Medicine, Continuing Medical Education, P.O. Box 3926, Springfield, IL 62708. **Credit:** Category I. **Contact:** Charles E. Osborne, Ed.D., Assistant Dean for CME. **Phone:** (217) 782-7711.

FEBRUARY

Allergy/Clinical Immunology

Case Presentations
February 23, 8:30 a.m., Holiday Inn City Centre, Chicago. **Sponsor:** The Illinois Society of Allergy and Clinical Immunology, 800 E. Northwest Hwy., Suite 101, Mt. Prospect, IL 60056. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 4½ hrs. **Contact:** Diane Kubis. **Phone:** (312) 255-1024.

OB/GYN/Family/Emergency Medicine

Medical Seminar at Sea (Caribbean Cruise)
For: Physicians. February 7-23. **Sponsor:** Southern Illinois University School of Medicine. **Fee:** $600. **Credit:** Category 1: 60 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean for CME. **Phone:** (217) 782-7711.

Nutrition

Clinical Nutrition in Office Practice
For: Family practitioners, internists, pediatricians, nurse practitioners and dieticians. Lecture/Workshops, February 6, Urbana, IL. **Sponsors:** Carle Clinic Association/Carle Foundation Hospital and University of Illinois College of Medicine, Urbana-Champaign. **Fee:** $40. **Reg. Limit:** 80. **Credit:** Category 1: 6 hours. **Contact:** Lisa K. Staley. **Phone:** (217) 337-3022.

Perinatal Medicine

4th Annual Meeting of Perinatal Association of Illinois
February 6, 12:45-4:15; February 7, 8:30-3:45; February 8, 8:30-12:00, Schaumburg, IL. **Sponsor:** University of Illinois College of Medicine. **Fee:** $95 (members); $125 (nonmembers). **Credit:** Category 1: 9 hours. **Contact:** Bruce A. Work, Jr., M.D. **Phone:** (312) 996-7430.

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POSITIONS AND PRACTICE

EMERGENCY MEDICINE—Illinois and Missouri. Full and part time positions available in emergency departments and clinics for qualified physicians seeking lucrative employment opportunities. Outstanding remuneration and comprehensive malpractice insurance provided. For further information contact Barbara Schiffman, Staffing Specialist. National Emergency Services, Inc., 1 Hollow Lane, Suite 304, Lake Success, New York 11042 or call (800) 645-4848.

U.S. AIR FORCE MEDICAL CORPS currently is accepting applications for physicians in the following specialties: Surgery (all specialties), Obstetrics/Gynecology, Otorhinolaryngology, Anesthesiology, Psychiatry, Orthopedic Surgery, Cardiology, Allergist, Family Practice, and Internal Medicine. For further information call collect: 1st Lt. Michael V. Vivoda: (312) 263-1207.

PHYSICIAN OPPORTUNITIES—Current openings for physicians of all specialities in the Illinois area and nationwide. Opportunities in solo, hospital and clinic based positions. For further information please contact Physician Recruiters Inc. at (312) 433-7180. All inquiries will be handled on a confidential basis.

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GENERAL INTERNIST wanted to associate in partnership, and later ownership, in multi-specialty medical facility in university town forty miles southeast of Chicago. Rapid practice growth is assured for industrious and conscientious physicians. Manager: T. Covey, M.D. (219) 462-4167 or (219) 762-3695.

OPHTHALMOLOGIST WANTED TO ASSOCIATE in partnership, and later ownership, in multi-specialty medical facility in university town forty miles southeast of Chicago. Rapid practice growth is assured for industrious and conscientious physicians. Manager: T. Covey, M.D. (219) 462-4167 or (219) 762-3695.

FAMILY PRACTICE FOR SALE. Palos Heights, IL. Equipment, building 1800 square feet. Affluent suburban community. Have practiced in this community 42 years. Retiring. For information call or write Samuel S. Leavitt M.D., 14515 Beacon, Orland Park, IL 60462; (312) 349-0105.

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PRIVATE PRACTICE Opportunities: Internal Medicine, family practice- OB/GYN- pediatrics. Guaranteed income-no capital investment. Affiliated with major university. Call (314) 727-2660.

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OB GYN: Small multi-specialty clinic in northern Indiana. Physician owned and operated. Beautiful lake community of 10,000. Near metropolitan centers. Salary plus bonus. Malpractice and health insurance provided. Contact: Kenneth E. Hoff, MD.; (219) 223-4337.

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ORTHOPEDICS: Small multi-specialty clinic in northern Indiana. Physician owned and operated. Beautiful lake community of 10,000. Near metropolitan centers. Salary plus bonus. Malpractice and health insurance provided. Contact: Kenneth E. Hoff, MD, (219) 223-4337.

FAMILY PRACTITIONER or internist-BC/BE: Excellent opportunity to replace retiring MD. Well established, very active practice, with excellent future income potential. Financial arrangements negotiable. Location in the far west suburbs of Chicago offers the best of city and suburban advantages. One hour to Chicago loop. Please send CV to Box #1181 c/o *Illinois Medical Journal,* Twenty North Michigan Avenue, Suite 700, Chicago, IL 60602.

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DECATUR, ILLINOIS: Full-time emergency medicine opportunities are immediately available for career-oriented physicians at our client hospital in Decatur. Work at a prestigious hospital with ultra-modern ED while earning an excellent guaranteed income. For more details on this opportunity and the excellent benefits provided, contact Dan Howard, National Accounts, Spectrum Emergency Care, Inc., P. O. Box 27352, St. Louis, MO 63141; 1-800-325-3982; (314) 878-2280.

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Young, dynamic group looking for final partner to grow with them. 300-bed community hospital, sees 26,000 patients. Area wide trauma center, and EMS resource hospital provides excellent clinical experience. Independent contractor status with remuneration of $60 per hour and annual increases through 1990. Malpractice cost fixed through 1990. Hospital contract through 1990 assures security; flexible scheduling with generous vacation time. Contact Dan Anderson (312) 986-0822.

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BEAUTIFUL OFFICE in modern building. Excellent busy location. Five minutes between two hospitals, three exam rooms, lab, private office, washrooms, parking. Waukegan, IL. (312) 244-3355 or (312) 662-1664.

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NORTHWEST SUBURBS—Medical office space to lease or share in attractive modern building. (312) 967-1300.

ONE HOLTER SCANNER (AO) plus four cassette recorders. Excellent condition. Asking price $5000.00 Call (312) 623-9700 9a.m.-5p.m.

PRESTIGIOUS NORTH SHORE medical center grossing over $500,000 available. Luxurious facility. Call for details. Professional Practice Sales, 540 Frontage Rd., Northfield, IL. 60093; (312)441-6111.

NORTHWESTERN, IL. (Near Freeport) General practice. Owner grossing $250,000+. Seeing 25-30 patients daily. Practice, equipment, and real estate priced at $230,000. Professional Practice Sales, 540 Frontage Rd., Northfield, IL. 60093; (312)411-6111.

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WOODRIVER, IL: 3,000 sq. ft. for lease. Nice building next to hospital and nursing home. Med. shop pharmacy now occupies 800 sq. ft. Ideal location for clinic, plenty of parking, will negotiate. Please call (618) 259-0085. Ask for Lee or leave message.

X-RAY MACHINE Universal 300 mA 125 KVP. Stationary table. Upright chest unit. Illinois state nuclear safety approved. Ms. Moore. Treister Orthopaedics. 25 West Chicago, Chicago, (312) 787-3111. New tube. Works perfectly.

PRIME MEDICAL OFFICE Space for rent. Two blocks south of St. James Hospital. Available immediately. For additional information please call (312) 238-4900.

MISCELLANEOUS

CERTIFIED PHYSICIAN ASSISTANTS for your busy practice. A free placement is offered through: Illinois Academy of Physician Assistants, 20 North Michigan Avenue, Suite 700, Chicago, IL 60602 or contact Michael Brown, PA-C, Professional Placement Chairman, (815) 740-7050.

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LOOKING FOR NEW or used *Cardiac Arrest And Resuscitation,* by Hugh Stephenson. (Mosby Printing, 1982, fourth edition only) I pay cover price. Call (312) 462-7852.

A STANDARD OF EXCELLENCE—Medical Manager 5.0 works with the IBM PC, XT and compatibles providing physicians with the most powerful, comprehensive, and flexible computerized medical office software available. In today's competitive world, manual office management is no longer a viable alternative. Automating a practice cuts costs, saves time, increases revenues, generates accurate information, and frees the office staff to work on other duties. Medical Manager 5.0 meets the unique demands of today's medical community. For additional information and/or a demonstration in your office, contact: Albert Livingstone & Associates, Inc., 55 E. Washington, Suite 1421, Chicago, IL 60602. (312) 782-5102.

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SORBITRATE®
(ISOSORBIDE DINITRATE)

Please consult full prescribing information before use. A summary follows:

INDICATIONS AND USAGE: SORBITRATE (isosorbide dinitrate) is indicated for the treatment and prevention of angina pectoris. All dosage forms of isosorbide dinitrate may be used prophylactically to decrease frequency and severity of anginal attacks and can be expected to decrease the need for sublingual nitroglycerin.

The sublingual and chewable forms of the drug are indicated for acute prophylaxis of angina pectoris when taken a few minutes before situations likely to provoke anginal attacks. Because of a slower onset of effect, the oral forms of isosorbide dinitrate are not indicated for acute prophylaxis.

CONTRAINDICATIONS: SORBITRATE is contraindicated in patients who have shown purported hypersensitivity or idiosyncrasy to it or other nitrates or nitrites. Epinephrine and related compounds are ineffective in reversing the severe hypotensive events associated with overdose and are contraindicated in this situation.

WARNINGS: The benefits of SORBITRATE during the early days of an acute myocardial infarction have not been established. If one elects to use organic nitrates in early infarction, hemodynamic monitoring and frequent clinical assessment should be used because of the potential deleterious effects of hypotension.

PRECAUTIONS: General: Severe hypotensive response, particularly with upright posture, may occur with even small doses of SORBITRATE. The drug should therefore be used with caution in subjects who may have blood volume depletion from diuretic therapy or in subjects who have low systolic blood pressure (eg, below 90 mmHg). Paradoxical bradycardia and increased angina pectoris may accompany nitrate-induced hypotension. Nitrate therapy may aggravate the angina caused by hypertrophic cardiomyopathy.

Marked symptomatic, orthostatic hypotension has been reported when calcium channel blockers and organic nitrates were used in combination. Dose adjustment of either class of agents may be necessary.

Tolerance to this drug and cross-tolerance to other nitrates and nitrites may occur. Tolerance to the vascular and antianginal effects of isosorbide dinitrate or nitroglycerin has been demonstrated in clinical trials, experience through occupational exposure, and in isolated tissue experiments in the laboratory. The importance of tolerance to the appropriate use of isosorbide dinitrate in the management of patients with angina pectoris has not been determined. However, one clinical trial using treadmill exercise tolerance (as an end point) found an 8-hour duration of action of oral isosorbide dinitrate following the first dose (after a 2-week placebo washout) and only a 2-hour duration of effect of the same dose after 1 week of repetitive dosing at conventional dosing intervals. On the other hand, several trials have been able to differentiate isosorbide dinitrate from placebo after 4 weeks of therapy and, in open trials, an effect seems detectable for as long as several months.

Tolerance clearly occurs in industrial workers continuously exposed to nitroglycerin. Moreover, physical dependence also occurs since chest pain, acute myocardial infarction, and even sudden death have occurred during temporary withdrawal of nitroglycerin from the workers. In clinical trials in angina patients, there are reports of anginal attacks being more easily provoked and of rebound in the hemodynamic effects soon after nitrate withdrawal. The relative importance of these observations to the routine, clinical use of isosorbide dinitrate is not known. However, it seems prudent to gradually withdraw patients from isosorbide dinitrate when the therapy is being terminated, rather than stopping the drug abruptly.

Information for Patients: Headache may occur during initial therapy with SORBITRATE. Headache is usually relieved by the use of standard headache remedies or by lowering the dose and tends to disappear after the first week or two of use.

Drug Interactions: Alcohol may enhance any marked sensitivity to the hypotensive effect of nitrates.

Isosorbide dinitrate acts directly on vascular smooth muscle; therefore, any other agent that depends on vascular smooth muscle as the final common path can be expected to have decreased or increased effect depending on the agent.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No long-term studies in animals have been performed to evaluate the carcinogenic potential of this drug. A modified two-litter reproduction study in rats fed isosorbide dinitrate at 25 or 100 mg/kg/day did not reveal any effects on fertility or gestation or any remarkable gross pathology in any parent or offspring fed isosorbide dinitrate as compared with rats fed a basal-controlled diet.

Pregnancy Category C: Isosorbide dinitrate has been shown to cause a dose-related increase in embryotoxicity (increase in mummified pups) in rabbits at oral doses 35 and 150 times the maximum recommended human daily dose. There are no adequate and well-controlled studies in pregnant women. SORBITRATE should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when SORBITRATE is administered to a nursing woman.

Pediatric Use: The safety and effectiveness of SORBITRATE in children has not been established.

ADVERSE REACTIONS: Adverse reactions, particularly headache and hypotension, are dose-related. In clinical trials at various doses, the following have been observed:

Headache is the most common (reported incidence varies widely, apparently being dose-related, with an average occurrence of about 25%) adverse reaction and may be severe and persistent. Cutaneous vasodilation with flushing may occur. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop (the incidence of reported symptomatic hypotension ranges from 2% to 36%). An occasional individual will exhibit marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration, and collapse) may occur even with the usual therapeutic dose. Drug rash and/or exfoliative dermatitis may occasionally occur. Nausea and vomiting appear to be uncommon. Case reports of clinically significant methemoglobinemia are rare at conventional doses of organic nitrates. The formation of methemoglobin is dose-related and, in the case of genetic abnormalities of hemoglobin that favor methemoglobin formation, even conventional doses of organic nitrate could produce harmful concentrations of methemoglobin.

DOSAGE AND ADMINISTRATION: For the treatment of angina pectoris, the usual starting dose for sublingual SORBITRATE is 2.5 to 5 mg; for chewable tablets, 5 mg; for oral (swallowed) tablets, 5 to 20 mg; and for controlled-release forms, 40 mg.

SORBITRATE should be titrated upward until angina is relieved or side effects limit the dose. In ambulatory patients, the magnitude of the incremental dose increase should be guided by measurements of standing blood pressure.

The initial dosage of sublingual or chewable SORBITRATE for prophylactic therapy in angina pectoris patients is generally 5 or 10 mg every 2 to 3 hours. Adequate controlled clinical studies demonstrating the effectiveness of chronic maintenance therapy with these dosage forms have not been reported.

SORBITRATE in oral doses of 10 to 40 mg given every 6 hours or in oral controlled-release doses of 40 to 80 mg given every 8 to 12 hours is generally recommended. The extent to which development of tolerance should modify the dosage program has not been defined. *The oral controlled-release forms of isosorbide dinitrate should not be chewed.*

DOSAGE FORMS AVAILABLE: Sublingual Tablets (2.5, 5, 10 mg); Chewable Tablets (5, 10 mg); Oral Tablets (5, 10, 20, 30, 40 mg); Sustained Action Tablets (40 mg).

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Working Together



The 1984 All-Member Conference in Rockford kicked off a massive effort by all segments of the Illinois medical profession to take our package of professional liability bills to the legislature. This cooperative effort involved physicians of all specialties, hospital action teams, spouses and hospital employees, and members of the lay public. The professional liability initiative that began in 1984 provides an effective blueprint for success in our 1987 return to the legislature for caps on non-economic damages. We must get caps to preserve fairness, and to ensure the financial stability of the insurance and re-insurance industries.

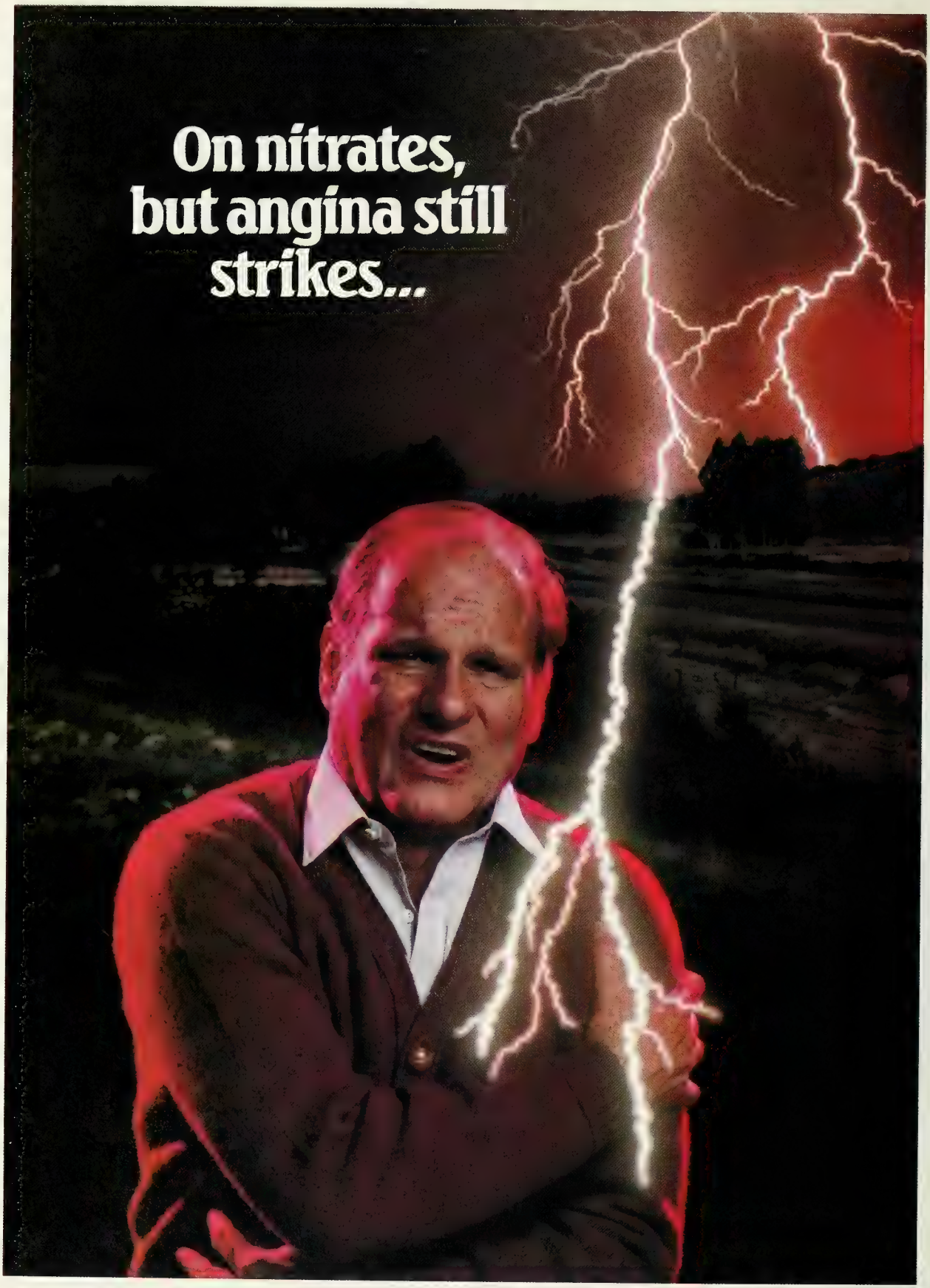
There have been innumerable articles in the lay press and business publications concerning the escalating problems in general liability and product liability. The cost of insurance is escalating so much that more and more companies, municipalities, school districts and similar entities are going bare (uninsured). More and more municipalities, police departments, school districts, and day care centers are finding that adequate insurance coverage is no longer available to them.

Much can be accomplished by working together. Physicians, patients, and families already know how to work together. Our action teams can effectively explain the problem to the media. Educated media can mean informed public opinion. And an informed public will seek legislative support for further reforms.

I'd like to take the opportunity, as I sign off this month, to extend warm holiday greetings to each of you and your families. ◀

Morgan M. Meyer

Morgan M. Meyer, M.D.
ISMS President


On nitrates,
but angina still
strikes...

For the many symptoms of anxiety



HAMILTON ANXIETY RATING SCALE

0 — Not Present
1 — Mild (occurs irregularly and for short periods of time)
2 — Moderate (occurs more constantly and of longer duration, requiring considerable effort on part of patient to cope)
3 — Severe (continuous, dominates patient's life)
4 — Very Severe (incapacitating)

	CHECK ONE				
	0	1	2	3	4
1. **ANXIOUS MOOD:** Worries, anticipation of the worst, fearful anticipation, irritability.			✓		
2. **TENSION:** Feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax.			✓		
3. **FEARS:** Of dark, of strangers, of being left alone, of animals, of traffic, of crowds.		✓			
4. **INSOMNIA:** Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors.			✓		
5. **INTELLECTUAL** (cognitive): Difficulty in concentration, poor memory.				✓	
6. **DEPRESSED MOOD:** Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing.			✓		
7. **SOMATIC** (muscular): Pains and aches, twitching, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone. (sensory): Tinnitus, blurring of vision, hot and cold flashes, feelings of weakness, prickling sensation.	✓				
8. **CARDIOVASCULAR SYMPTOMS:** Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat.			✓		
9. **RESPIRATORY SYMPTOMS:** Pressure or constriction in chest, choking feelings, sighing, dyspnea.			✓		
10. **GASTROINTESTINAL SYMPTOMS:** Difficulty in swallowing, wind, abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi, looseness of bowels, loss of weight, constipation.			✓		
11. **GENITOURINARY SYMPTOMS:** Frequency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence.				✓	
12. **AUTONOMIC SYMPTOMS:** Dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair.	✓				
13. **BEHAVIOR AT INTERVIEW:** Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, belching, brisk tendon jerks, dilated pupils, exophthalmos.			✓		

TOTAL: 18 PSYCHIC: 12 SOMATIC: 6

The myriad of clinical symptoms associated with anxiety, as listed in the Hamilton Anxiety Rating Scale, are difficult enough to list, much less treat.
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Please see brief summary of prescribing information on adjoining page.

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Brief Summary of Prescribing Information

INDICATIONS—For management of anxiety disorders or short-term relief of symptoms of anxiety; for symptomatic relief of acute alcohol withdrawal; for adjunctive therapy in partial seizures.

Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic. Effectiveness in long-term management of anxiety (over 4 months) not assessed by systematic clinical studies. The physician should periodically reassess usefulness for each patient.

CONTRAINDICATIONS—Known hypersensitivity to the drug. Acute narrow angle glaucoma.

WARNINGS—Not recommended for use in depressive neuroses or psychotic reactions. Caution patient against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for seveeral months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

Pregnancy and Lactation: Minor tranquilizers should almost always be avoided during first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

PRECAUTIONS—Observe usual precaution in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

ADVERSE REACTIONS—Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function tests, decreased hematocrit, decreased systolic blood pressure.

INTERACTIONS—Potentiation may occur with ethyl alcohol, hypnotics, barbituates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

OVERDOSAGE—Take general measures as for any CNS depressant.

SUPPLIED—TRANXENE 3.75, 7.5, and 15 mg capsules and scored tablets. TRANXENE-SD Half Strength 11.25 and TRANXENE-SD 22.5 mg single dose tablets.

REFERENCE

1. Data pooled from 19 studies recorded as part of original Tranxene New Drug Application. 546 patients under treatment for anxiety were analyzed. 387 with baseline HARS 18 or greater entered in study. Following 7-day placebo lead-in period, patients in drug group (n = 235) received Tranxene® (clorazepate dipotassium) 7.5 mg for 21 days. Data on file, Abbott Laboratories.

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Focus on Communication

The governing council of the ISMS Hospital Medical Staff Section (HMSS) agreed at its October 23 meeting to inform medical staffs in Illinois about new JCAH standards taking effect January 1, 1986. These new standards will ensure that medical staffs in multi-hospital systems and corporately restructured hospitals have a mechanism to communicate with corporate management and governing bodies. Such a mechanism is essential to effective medical staff participation in policy decisions affecting patient care services in hospitals or systems with distant or multiple layers of management and governance.

The new standards are significant in that increasing numbers of hospitals are joining regional or national systems in order to have access to capital, economies of scale in purchasing, and participation in alternative health care delivery plans. As a result, more medical staffs will be working in hospitals with a governing body that is not the only or ultimate authority on issues concerning the medical staff. In some instances, the ultimate organizational entity responsible for patient care delivery may reside outside the hospital or even in another state. In that event, the staff could find itself isolated from that important body.

The precise choice of a communications link is a matter that the new JCAH standards leave up to each individual system. The governing council of the ISMS Hospital Medical Staff Section has agreed to encourage medical staffs in multi-hospital systems or corporately restructured hospitals to participate in establishing an effective communications link between themselves and corporate governance and management. One method is an advisory council comprised of physicians from each system hospital that would meet with corporate management and governance on a regular basis. In one instance, such an advisory council convinced the corporate authorities to scale down proposed required minimum limits of liability insurance.

Annual Meeting Scheduled

The inaugural annual business meeting of the ISMS Hospital Medical Staff Section (HMSS) will be held Saturday, March 1, 1986 at the Palmer House in Chicago. All Illinois medical staffs are eligible to send a representative and participate in this meeting. This is an opportunity to be directly involved with ISMS policy making. The Section will have delegate representation and voting in the ISMS House of Delegates (April 4-6, 1986).

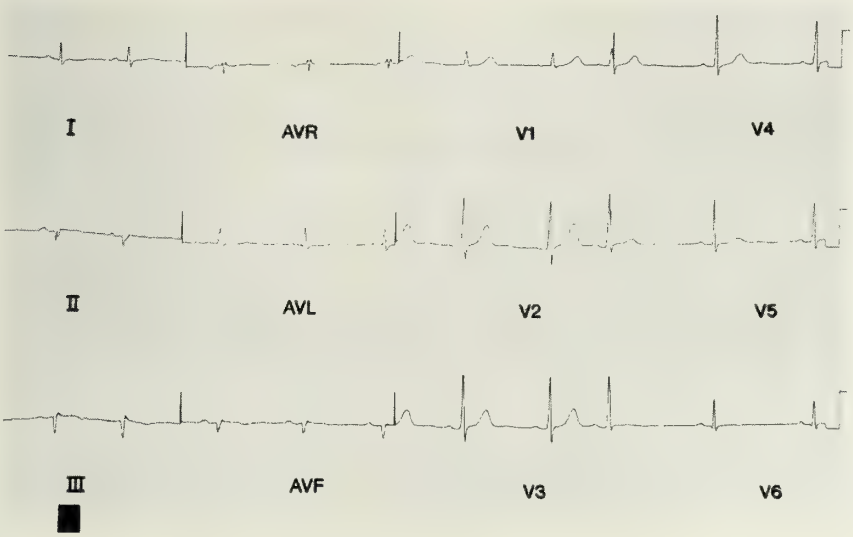
The requirements for medical staff representation in the Section are: (1) ISMS membership, (2) active staff privileges and (3) election by the medical staff. Representatives of medical staffs in the AMA HMSS are automatically certified as members in the ISMS Section.

The deadline for introducing resolutions into the ISMS HMSS business meeting is February 14, 1986 (15 days prior to the meeting). Any resolutions introduced after that date must be approved by two-thirds of those present at the annual meeting in order to be considered. Business will also include elections for the following Governing Council offices: Secretary (Cook County), Treasurer (Downstate), At-Large Member (Downstate) and At-Large Member (Cook County). Each office is for a two-year term.

Resolution formats will be mailed to all hospital medical staffs in the near future, along with other information about the meeting. Further information is available through the ISMS Division of Field Services: (312/782-1654). ◀

EKG OF THE MONTH

CONTRIBUTING EDITOR JOHN F. MORAN, M.D., SECTION OF CARDIOLOGY, DEPARTMENT OF MEDICINE, LOYOLA UNIVERSITY STRITCH SCHOOL OF MEDICINE



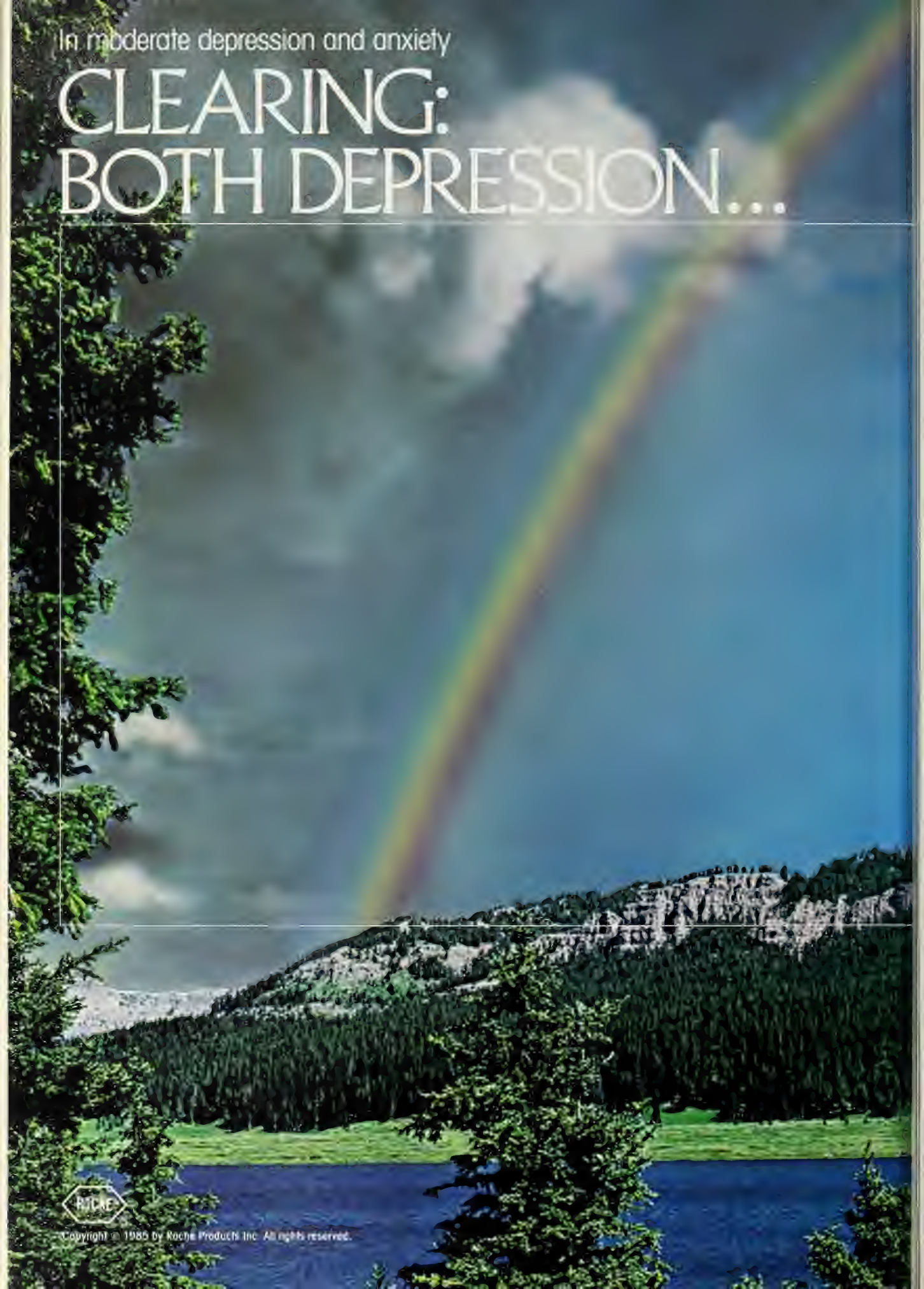
This is a 47 year old salesman who was awakened by severe substernal burning and left arm numbness. He came to the emergency service, where an acute myocardial infarction was diagnosed. He made an uneventful recovery. After a period of rehabilitation, he was ready to return to work. Two months after the infarction he had an exercise ECG. This was abnormal and accompanied by retrosternal chest burning at five minutes of exercise. His examination at that time showed a blood pressure of 130/90mmHg, pulse 60 beats per minute. His lungs were clear and his cardiac exam was normal. This twelve lead ECG was obtained.

Questions:

1. **The ECG shows:**
 - A. Severe right ventricular hypertrophy.
 - B. Left axis deviation, probably left anterior hemiblock.
 - C. Inferior wall myocardial infarction.
 - D. True posterior wall myocardial infarction.
 - E. B and C only.

2. **Which of the following statement(s) is/are correct?**
 - A. Angina following a myocardial infarction precludes a successful aortocoronary bypass surgery because the left ventricle has already been damaged by the infarction.
 - B. Left axis deviation cannot be caused by left anterior hemiblock in the setting of inferior wall myocardial infarction.
 - C. Exercise induced angina after a myocardial infarction is an indication for coronary angiography.
 - D. All of the above.

(Continued on page 402)



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A Voice for Students

By Jodie Rai/Secretary-ISMS-MSS

I have only fuzzy recollections of Medical Student Section meetings I attended as a first year medical student. Acronyms like HMO, PPO, DRG, AMA-HOD and AMA-BOT whirled around my wondering head. Detailed discussions about AMA policy, the effects of Medicare changes, and the Framingham Study only confused me further. Maybe I was more naive than most first year students. Yet, I credit my involvement with the ISMS-MSS (Illinois State Medical Society-Medical Student Section) with a large part of my education about the realities of medicine. In addition to education, the ISMS-MSS gives medical students a means to act on informed concerns.

The MSS 1985 Fall Seminar with Dr. Edward F.X. Hughes, M.D., M.P.H., director of the Center for Health Services and Policy Research of Northwestern University and professor in both its Management and Medical Schools, is an example of the educational activities we offer to medical students. Dr. Hughes met with us, a group of 14 first to fourth-year medical students, to discuss the effects of changes in funding by third party payers on medical education, and other concerns that we expressed.

Some first and second year students at the meeting were interested in, but felt uninformed about, issues that will affect them. Mike Friedman, a second year student, thought that his medical education was not preparing him for the economical aspects of the practice of medicine. "The system encourages us to spend a lot of money . . . while people are falling through the cracks (who) can least afford it," he said. Other students questioned the role that other professionals, lawyers and businessmen especially, have assumed in the health care delivery system. What can be done about the professional liability crisis? Who will be the ultimate decision makers, businessmen or physicians? What is the future of HMOs and PPOs and what contributions will they make in the costs of undergraduate and graduate medical education?

Although Dr. Hughes felt the medical profession and the health care industry have rough times ahead, he was optimistic about the long-term horizon. He believes that government programs have contributed to escalation in the costs of health care, and such innovations as DRGs are efforts to increase efficiency in these programs. Belt-tightening will continue in these and private insurance programs, he said. Businessmen will cut costs and increase efficiency, but also maintain quality. Ways will be found to finance graduate medical education.

The perennial student anxiety, loans, was also voiced. Fourth year medical students discussed particular residencies and worries about money for residencies in general, especially extended residencies. One student was concerned about funds for research. For basic research, Dr. Hughes believed, there would be money, because public support of medical innovation is deeply rooted in twentieth-century American political consciousness, and there is much to show for the investment. Those who attended found the program, discussion and Dr. Hughes' comments to be stimulating and informative.

The Medical Student Section has another goal, that of action on our concerns. To us, medical organizations like the CMS, ISMS and AMA (yes, all those acronyms again!) are effective instruments. We have originated many important resolutions adopted by the AMA. Recently, we have asked the AMA to study how Medicare budget cuts will affect medical education, and to suggest alternate sources of funding. We asked the AMA to study the safety of UV radiation levels used in tanning salons, and the validity of a tobacco company advertising campaign which refutes the results of the Framingham Study. In asking the AMA to oppose the use of nuclear weapons and to support verified arms reduction on the part of all nations, we live up to our reputation as the "conscience" of the AMA. Students sit on AMA councils, and a student is now a full member of the AMA Board of Trustees. The ISMS-MSS actively attends important meetings of the ISMS and AMA. In these ways and others, we not only educate ourselves about issues that affect us, but also act on them. ◀

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What Makes Them Different?

Medical Marriages

*By Kathleen T. Jordan/Chicago**

What makes a medical marriage different from others is not just the physician's dedication to work, the time away from home or the preoccupation with others' problems. Those factors are present in other relationships. A medical marriage is different partly because of public expectations and medical training, as well as the intelligence of the partners themselves.

Physicians' marriages have been the subject of public interest in recent years, as print and broadcast media have focused on the pitfalls of those relationships. Unfortunately, the exposure has done little to explain why those pitfalls arise.

Physicians, for example, expend more energy, time, and money to attain their goals than most people. They are taught in medical school that working harder is better, and in residency, that the role of omnipotent healer must be accepted at the expense of personal needs and feelings. They live daily with the knowledge that people's happiness, security, and future depend upon their decisions, and with an intelligence that makes them aware that they are unable to solve every problem that comes their way.

Physicians' spouses have similar levels of intelligence, education, and motivation. They also share the unique emotional demands and time constraints, and the public expectation that they will be more caring and understanding than others simply because they are married to physicians. These pressures are present even if they try to separate themselves from the role of "doctor's spouse."

Because of these special circumstances, medical auxiliaries have for some years addressed the pressures that can arise in medical marriages. The American Medical Association Auxiliary has published booklets and articles on the subject, and held educational sessions for members. A family advocacy committee under development by the Illinois State Medical Society Auxiliary will help members with problems of many kinds, including the stresses of medical marriage.

These efforts emphasize that an important step to a satisfying relationship is to leave behind the "as soon as" syndrome that began in residency, and to understand that things will not fall magically into place at some future point. Those who are caught in the cycle of postponed hopes must realize that it carries a substantial risk—a growing backlog of unmet needs that can blow a marriage apart.

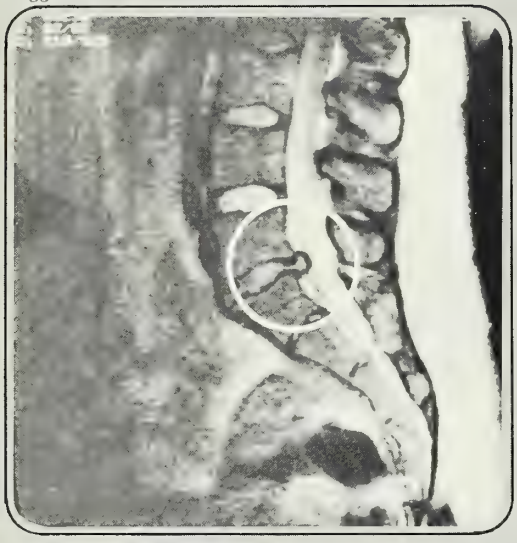
Auxiliary programs seek to emphasize that rather than believing everything will be fine "as soon as," physicians and spouses together need to establish an environment of caring, respect, and acceptance. They need to share the joys as well as the sorrows, and to focus on the unique mutuality of the relationship, rather than its pitfalls. A medical marriage should be one from which both partners gain the strength to deal with the sorrows and the ability to savor the joys. ◀

Ms. Jordan is the editor of the AMA Auxiliary publication, FACETS.

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IMJ

Illinois Medical Journal
Illinois State Medical Society

Volume 168, No. 6
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Case Report and Review of Pulmonary Manifestations

AIDS

By Raymond A. Dieter, Jr., M.D., Carol Wilhoit, M.D. and Steven Lewis, M.D./Glen Ellyn and Winfield

In recent years, we have become aware of several new disease entities, including Reyes Syndrome, Legionnaires Disease, and AIDS (Acquired Immunodeficiency Syndrome). Due to widespread publicity, these processes have become widely known to both the medical and lay communities in a short period of time. The knowledge of their existence and the severity of the process implies a poor prognosis to afflicted individuals.

AIDS syndrome is the most recent of these entities, and statistically carries the poorest prognosis. The syndrome occurs primarily in homosexual males, intravenous drug users, Haitians immigrating to the U.S.A., hemophiliacs and blood transfusion recipients.[1] The entity was first recognized in 1979. A total of 1,641 cases had been reported to the Center for Disease Control as of June 20, 1983. By January, 1985, that number had grown to 7,986. This syndrome generally presents with a prolonged prodrome which includes generalized lymphadenopathy, recurrent fever and weight loss.[2] The occurrence in Illinois, and particularly in the greater Chicago area, seems to be increasing. A patient who presented with the above symptoms and, in addition, progressive pulmonary symptoms and Kaposi's sarcoma, is reported. A review of the pulmonary problems of the AIDS patient is also presented.

This 40 year old white male was admitted to the hospital with a history of herpes zoster involving the ophthalmic branch of the right trigeminal nerve and the nasal ciliary nerve. His first visit had occurred five years before, when he had impacted cerumen in both ears with pain and diminished hearing. Three years later, he had had a pale yellow drainage from both ears associated with pain for two weeks. At this time, he weighed 181 pounds.

A year later, the patient had developed a chalazion of the left upper eyelid and the anterior uveitus had recurred. Five months after this he bled from his gums. Five years after the first examination, a diffuse erythematous rash had developed while on ampicillin and probenecid treatment for a positive gonorrhea culture. The titer for syphillis was rising.

Five months later the patient reported a loss of appetite, exhaustion, certain foods burning his mouth, nodules on his tongue, and weight loss to 169 pounds. He was homosexual in preference and had a left perianal lesion of the herpes simplex type. He was treated for syphillis with pencillin. Diarrhea, dizziness and a productive cough developed. Laboratory evaluation showed a leukopenia, an increased serum globulin, and entamoeba histolytica on stool exam. He had oral candidiasis and no cervical adenopathy. Chest x-ray was normal.

A month later the patient weighed 156 pounds, had a blood pressure of 84/60mmHg, and an oral temperature of 101-103°F. There was a decreased percentage of T-helper cells and a relatively increased percentage of suppressor cells. This resulted in a markedly decreased helper to suppressor ratio. He was anergic to five skin test antigens and continued to have leukopenia and mild anemia.

These results, in conjunction with fatigue, weight loss, thrush fevers, and now lymphadenopathy, were consistent with a prodromal phase of AIDS. The white blood cell count was 2,900 with a differential of 39% polys, 5% bands, 40% lymphocytes, 9% eosinophils, 6% monocytes, 1% basophils. The total lymphocyte count was 1,160 and platelet count was 178,000.

Following a course of tetracycline and metronidazole, no parasites were noted in the fecal exam. Bone marrow study demonstrated a normocytic normochromic anemia with reactive plasmacytosis. Biopsied left femoral lymph nodes were

consistent with Kaposi's sarcoma. Gallium scan now demonstrated increased radioactive uptake over both lung fields despite the normal appearance on the chest x-ray. Ocular exam demonstrated "cotton-wool" infarct in the nerve fiber layer of the retina (two spots on the right and one on the left). One month later his weight was 149 pounds and the fever, tachycardia, non-productive cough and oral white plaques persisted without any adenopathy. Upon hospitalization for interstitial pneumonia, he was found to be weaker, to weigh 142 pounds, to have dysphagia, to have a dry cough productive of a scant amount of white foamy material, and to have a small left posterior cervical node. Lung biopsy demonstrated Kaposi's sarcoma. He continued to deteriorate and expired shortly thereafter.

Discussion

This patient presented with a prolonged clinical course of two to three years consisting of repeated and various system involvements, including the ears, eyes, skin, lungs and lymph nodes. He further developed repeated inflammatory problems—usually infectious in nature—including herpes zoster, entamoeba histolytica, gonorrhea, syphillis, yeast and herpes simplex. With symptom progression, lymph node and lung biopsy were diagnosed as Kaposi's. The clinical course was that of a progressive multi-system deterioration and failure compatible with AIDS—a possible retroviral process.

Initially he had no respiratory symptoms or findings, despite repeated examinations by physicians in multiple institutions. As the disease progressed, he developed a slight non-productive cough with no chest x-ray findings. Gallium scan at that time demonstrated a diffuse increased activity over both lung fields. The cough slowly became more marked and produced a white foamy material. As the symptoms progressed, the chest x-ray began to show a bilateral mild to moderate infiltrate, especially basilar.

Review of the *Morbidity and Mortality Weekly Report* (MMWR) statistics, from the U.S. Center for Disease Control (CDC) shows that pneumocystis carinii pneumonia (PCP) is the most common life threatening opportunistic infection in AIDS patients (51% of the primary diagnoses). This agent is quite commonly and readily found in bronchoscopic or tissue samples in this group of patients. In the immunosuppressed patient undergoing chemotherapy for malignant disease on the other hand, it is often a very difficult diagnosis to establish. In the AIDS patient, the sputum may even be positive for the pneumocystis carinii organism. Transbronchial lung biopsy may be a very sensitive diagnostic aid in the AIDS patient with PCP. Touch preparations from the bronchial brushings are less helpful. Pentamidine may lead to clinical improvement but death due to relapse of PCP or opportunistic infection usually ensues. Chest x-rays may be relatively normal in the AIDS/PCP patient but a widened P(A-a)O2 is very suggestive of the diagnosis and lung biopsy should be considered. The disease usually appears as an interstititial pulmonary pneumonia and recurrent pneumothoraces have been observed in the patient with subpleural PCP infection.[3]

Association with Kaposi's Sarcoma

Kaposi's sarcoma occurs in 26% of the AIDS patients without PCP.[4,5] This increased incidence of diagnosis of Kaposi's sarcoma of the lung over the past four to five years is in direct contrast to its extreme rarity in the past. On x-ray of the chest, the tumor may appear as an infiltrate or nodular density which does not clear with treatment. Examination of the lung demonstrates a multinodular process with small to medium sized nodules (up to 2-3cm) which are firm, bulging, and bright to dark red in color. Microscopically, the lung may show areas of fibrovascular proliferation with hemosiderin deposition. The stroma may be edematous and contain extravasated blood cells. The homosexual AIDS patient seems more susceptible to Kaposi's than does the drug addict AIDS patient. No curative treatment is available for Kaposi's sarcoma. Isolated lesions may be excised and cutaneous lesions radiated. Chemotherapeutic regimens are now being investigated for treatment of the sarcoma. An isolated case of asthma in association with Kaposi's sarcoma and pulmonary infiltrates has been reported.[6]

No evidence of airborne transmission has been presented but when performing bronchoscopy upon a suspect patient a wrap around "welder's type" shield or goggles are recommended at this time. No cases have been reported among casual friends or relatives, which again suggests that airborne transmission is not a major contact source. The incidence of liver disease and hepatitis B in homosexual patients tends to lower immune resistive capabilities. This may lend itself to the slow and progressive AIDS syndrome with all of its manifestations, including the pulmonary pathology. Children of AIDS victims appear to be at an increased risk and begin to develop symptoms by three to six months of age. Symptoms are similar to those of respiratory infections and recurrent pneumonias. Initially, health care workers had expressed reluctance to treat AIDS patients.[7] However, Dr. John Conte of the University of California (San Francisco) and a select committee have stated that patients do not need to be isolated, may hold jobs, and individuals may treat the patient acording to their reported set of guidelines.[7] The CDC has also issued a set of guidelines (including dental and autopsy) regarding contact with the suspect or proven AIDS patient.[8] These include a discussion on wearing gloves, masks, protective eyewear, and instrument sterilization.

Mycobacterium avium-intracellulare (MAIC) infections have been reported in a number of AIDS patients. This is usually disseminated and may be proven on culture or acid fast studies of tissues examined. Microscopically, the tissue may not show the typical granulomatous picture of mycobacterial disease. Sputum, urine, tissue, and/or blood cultures must be done in these patients. MAIC is frequently resistant to antituberculous drugs and thus the patients may fail to respond to anti-mycobacterial therapy. MAIC appears to be a "second

phase" developing in the PCP treated patient.[3] Opportunistic pulmonary infestations are the most common lung manifestations mentioned with AIDS. In addition to PCP and MAIC, cryptococcal and cytomegalovirus (CMV) has been reported in a smaller percent of patients. Other less common pulmonary manifestations reported may include the bronchospastic patient and acute staphylococcal aureus bronchopneumonia with progressive respiratory failure. Concern regarding bronchoscopic transmission of the disease has led to special handling of the instruments, including the bronchoscope, biopsy forceps, and brush and tissue (washing and biopsy) specimens, similar to care given to hepatitis patients. Stool and needle precautions may be warranted. Other complications of AIDS which may be seen include the mycobacterium tuberculosis, cryptosporidium, toxoplasmosis, aspergillus infections, non-Hodgkin's lymphoma and Burkitt's-like lymphoma.[9]

Summary

The case report of a forty year old white male with Acquired Immunodeficiency Syndrome (AIDS) is presented. His development of multiple infectious complications—including herpes simplex and zoster, gonorrhea, syphillis, entamoeba and Kaposi's sarcoma—were reviewed. Multiple system deterioriation and, in particular, pulmonary failure, were noted. Review of the various pulmonary manifestations of AIDS was presented. These include pneumocystis carinii, mycobacterium, Kaposi's sarcoma, cytomegalovirus, and progressive respiratory insufficiency. ◀

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Intracranial Vascular Malformation and Astrocytoma

By Dipakkumar Shah, M.D., Mohammad H. Naheedy, M.D. and Robert O'Hara, M.D./Hines & Maywood

A case of concurrent intracranial vascular malformation and malignant glioma is presented. CT scan alone was not sufficient to separate these diagnostic entities. However, angiography made the correct diagnosis prior to surgery, which did change the patient's management. Therefore, it is suggested that angiography can assist diagnosis when there is no definite correlation between the CT scan and clinical findings.

Concurrent intracranial vascular malformation and aneurysm have been diagnosed and reported with increasing frequency. Although multicentric gliomas have been reported, concurrent intracranial vascular malformation and malignant glioma are infrequently observed. Only a single case report prior to the advent of computed tomography has been noted.[1] We report such a case with computed tomographic and angiographic findings.

Case Report

A 35-year old white male presented with focal seizure beginning on the left side of his face which became generalized. He awakened after 20–30 minutes of unconsciousness and was brought to the emergency room when another generalized seizure with the same pattern was noted. The patient had a history of chronic alcoholism with alcoholic liver disease and coagulopathy.

Physical examination revealed blood pressure of 158/90, pulse 80/min. and respiration 17/min. The neurological examination revealed a well oriented, non-agitated white male with normal higher cortical functions. The cranial nerve examination and fundi were normal. Pupils were symmetric and reactive. Extraocular muscle examination revealed end point nystagmus to the left lateral gaze. No sensory or motor deficit was noted and laboratory studies were normal. The EEG showed mild diffuse bilateral cerebral dysfunction compatible with postictal state. Radionuclide brain scan revealed normal flow study as well as static scans after three hours. Non-contrast computed tomography of the brain showed an area of decreased attenuation value in the high medial portion of the right fronto-parietal lobe with extension to temporal

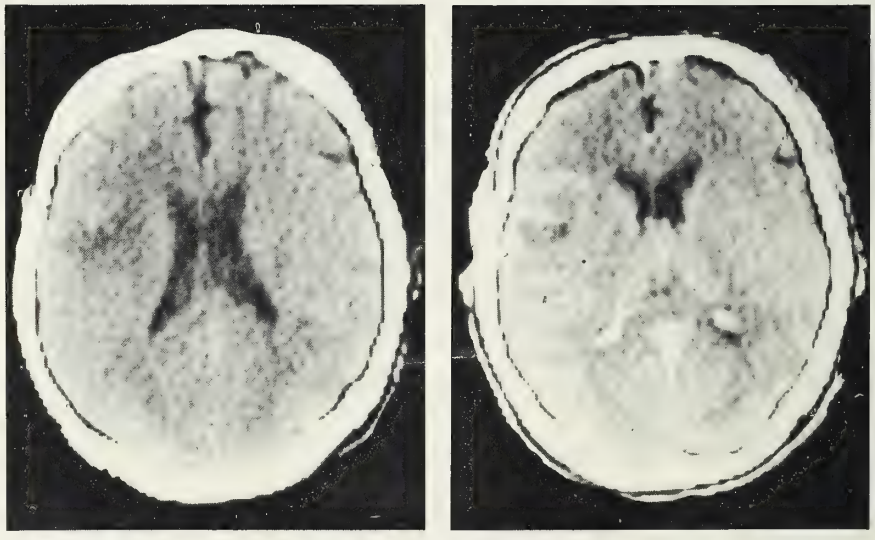


Figure 1A Figure 1B

Figure 1A: CT scan without contrast showing an area of decreased attenuation value in the right temporal region. Figure 1B: Following contrast injection, there is a small area of enhancement at the periphery of lesion.

lobe. Intravenous injection of contrast media elicited minimal enhancement in this region. There was mild mass effect upon the sylvian fissure and right lateral ventricle. (Figures 1A,B) In addition, after contrast examination there was a nodular area of enhancement in the left frontal lobe in high convexity. (Figure 2)

Due to the lack of known primary malignancy and multiplicity of lesions on CT scan, the possibility of multicentric primary brain tumor or infectious process was considered. Right carotid angiography for further evaluation revealed an avascular mass in the region of the right fronto–temporo–parietal region with some stretching of the middle cerebral artery branches. (Figures 3A,B) No early draining veins were identified. Left carotid angiography revealed a parasaggital vascular malformation which was mainly supplied by the branches of the left anterior cerebral artery with a large

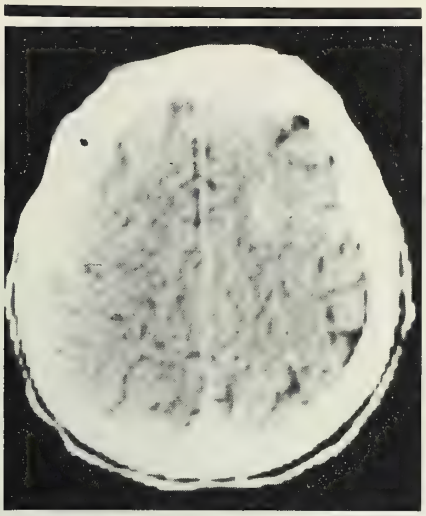


Figure 2: Post contrast study at higher level: There is nodular enhancement in mid-left frontal lobe in high convexity.

single draining cortical vein. (Figure 4) A diagnosis of primary brain tumor in the right cerebral hemisphere and vascular malformation in the left cerebral hemisphere was made on the basis of clinical findings indicating a lesion in the right cerebral hemisphere. Craniotomy and biopsy of the lesion in the right hemisphere revealed abnormal deep gyral pattern with markedly yellowish solid mass. Multiple biopsies revealed a malignant astrocytoma of Grade III to IV. The patient received 4500 rads of radiation to whole brain with an additional 1500 rads to the primary location in the right hemisphere.

Postoperative course was seizure free for the first six months at which time left facial focal seizure was noted and controlled by increasing the dose of phenobarbital.

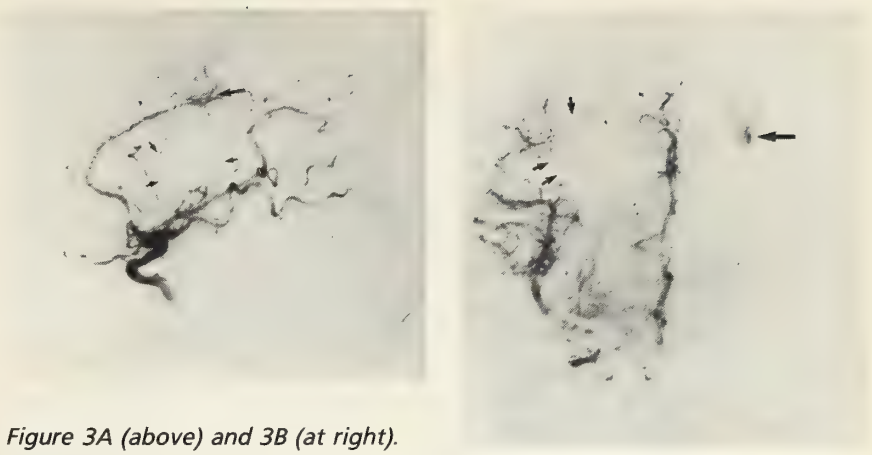


Figure 3A (above) and 3B (at right).

Figure 3A: Lateral projection of right internal carotid artery angiogram demonstrating avascular mass in the temporal lobe with stretched vessels (small arrows) with questionable abnormal vessels in mid-frontal lobe (large arrow). Figure 3B: Frontal projection of right internal carotid artery angiogram revealing abnormal vessels to be a vascular malformation in the other hemisphere (large arrow). Note the avascular mass on the right side.

Discussion

Multiple intracranial tumors can be classified either as primary neoplasms of the brain or secondary metastatic tumors. The primary intracranial neoplasms are glioma, cranial nerve tumors and meningeal tumors. The incidence of multiple glioma in autopsy series is about 0.06%. However, among intracranial tumors in general this increases to 4.3%. In these series, 9.3% of glioblastoma multiforme and 6% of astrocytomas were multiple.[2-4]

On the other hand, 6.2% of intracranial vascular malformations were associated with one or more aneurysms in a cooperative study of aneurysms and subarachnoid hemorrhage.[5]

Secondary metastatic tumors of the brain have different origins, most commonly, lung, breast, kidney and, less likely, G.I. tract. Sixty percent of these are considered to be operable, benefiting the quality and length of the patient's survival.[6]

Intracranial tumors are rarely associated with those of other organs. In a single case report, Warren[1] noted a case of glioblastoma multiforme with association of intracranial vascular malformation as well as arteriovenous malformation in the lung.

In general, multiplicity of the lesions is highly suggestive of metastatic lesions. However, granulomas

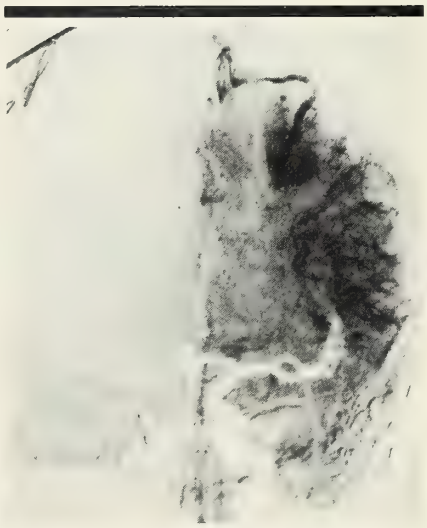


Figure 4: Frontal projection of left internal carotid artery angiogram showing the vascular malformation with single draining cortical vein on the left.

from unusual infections and abscesses can also be multiple in nature.[7] Unfortunately, since the advent of CT scanning, especially with high resolution CT scanners, some neurosurgeons may biopsy or perform surgery for intracranial lesions on the basis of CT scan findings alone, to avoid complications resulting from invasive diagnostic studies. This procedure carries some risk of unexpected surgical pathology.[8] In our patient, CT scan showed one lesion in each hemisphere. Although statistically, on the basis of CT scan finding alone, metastatic lesion was highly likely, due to right hemisphere clinical presentation alone, angiography was performed for further evaluation. In fact, angiography was very helpful and diagnostic in finding vascular malformation as well as demonstrating avascularity of the tumor in the right hemisphere. ◂

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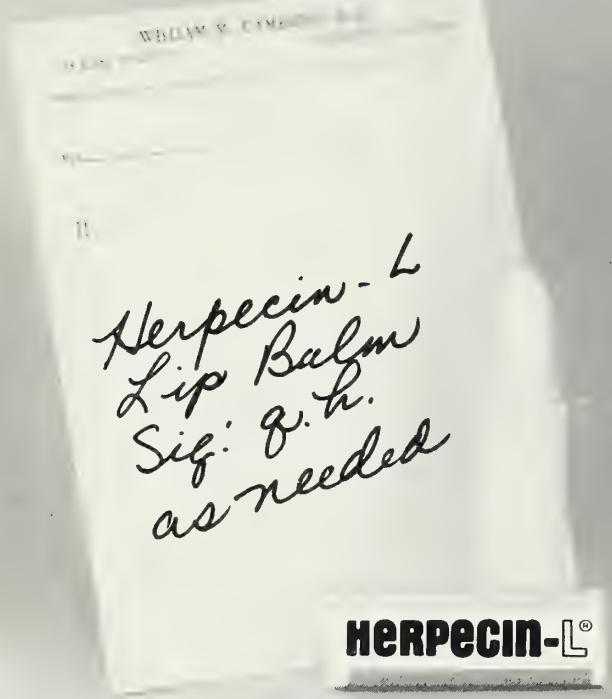
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The Importance of Ernest

By Daniel K. Bloomfield, M.D./Urbana-Champaign

The text below was first presented as the fourth convocation address at the University of Illinois College of Medicine at Urbana-Champaign, June 6, 1984.

There is a very popular nineteenth century play by Oscar Wilde entitled "The Importance of Being Earnest." It is a morality play about a young suitor which has a title that is more interesting in my view than the play itself. But given the popularity of the title and its public recognition, I would like to speak to the 1984 graduates of this medical school on a variation of that title, not its theme. I'd like to talk about "The Importance of Ernest," *i.e.*, Ernest, your patient, who seeks your care and your help, not "earnest" as in the title of the play. It allows me to give you one final message about a most important element in the practice of medicine: the importance of appreciating the importance of each and every patient.

All of you sit here as examples of high achievers in American society. You excelled in high school; some were valedictorians. You excelled in college, at least enough to allow you to be among the small percentage of college graduates eligible to attend medical school. You survived a medical school admission process that takes only one applicant in three and you have completed four years of a rigorous program in medical education. Your education level now is in the top 5% of the United States and probably the top 0.1% in the world. By the time you have completed your residency you will be at even more lofty levels. You will soon enter a professional office where many of you will be able to hang out a series of intimidating diplomas that will attest to this achievement and more. In short, you have all the ingredients and background to make you haughty, arrogant and self-satisfied.

Given your advanced education and social status as a physician you can survive aloof from society and from your patients. You may practice an acceptable brand of medicine without ever developing the necessary sensitivity to practice that medicine with a humanity which separates the excellent from the good. The publicly perceived failing of so many physicians is often related to the absence or muting of humanity in their approach to their patients.

The dean of any medical school serves as a repository for horror stories about the local practice of medicine. If something goes wrong to a citizen in this city, it seems that somehow I am responsible for redressing whatever malfunction has occurred.

People have a certain fascination in telling medical misadventures. Most of this grapevine seems one-sided and more often than not relates to the difficulty connected with the early detection of serious disease. Brain tumors are easily diagnosed when there is an obvious neurological deficit, but are much harder to identify when they present with a headache indistinguishable from the hundreds of tension headaches one sees over time.

Berton Roueche wrote in the New Yorker Magazine of July 16, 1979, about the distressing saga of a young woman with Wilson's Disease who was misdiagnosed and therefore mistreated by a series of psychiatrists and university hospital physicians. The woman was classified as a neurotic/psychotic with bizarre symptoms until the true nature of her disease was diagnosed two years after the onset of symptoms by a doctor in a community

mental health clinic. The practice of medicine, particularly the primary care sector, is like walking through a mine field. It's so simple until you step on a mine. The fact that mines are few and far between does nothing to make them any less dangerous or any less deserving of our attention.

But diagnosis is not the problem I wish to deal with. Medicine, for all its progress, remains less than an exact science. What most upsets those who anguish over medical tales is not so much diagnoses, but the difficulties they have in simply talking with their physicians. Communication problems with the doctor lead patients to a perception of physician arrogance.

I chose the words "perception of physician arrogance" carefully, because most doctors have no concept that they may appear arrogant to their patients and they have less insight concerning the patient's perception of them. Indeed physicians are often resentful and defensive about the assertion that they are in any way too haughty to their patients.

The pathos of the young woman with Wilson's Disease was mainly in the impersonal, haughty and perfunctory attitudes taken by well-credentialled physicians. Doctors who represented high levels of professional competence were also doctors who could not come to grips with the humanity of a patient acting in bizarre ways because she suffered from a disease that was organic in nature. In the course of her disease, the patient attempted suicide and divorced her husband while being managed by three different private psychiatrists and the psychiatric ward team of a leading university medical center. All were wedded to a rigid structure which carefully documented, "This is the first (hospital) admission for this 26-year-old divorced white woman from (city) referred by Dr. _____. Chief complaint is given by the father who reports her as 'becoming catatonic'." The admission concluded, "Final Diagnosis: Hysterical neurosis, conversion type." It was all wrong, of course, so that the proper diagnosis was masked by the overconfidence of physicians who didn't take the time to listen carefully to a patient who was not "crazy." The failure to listen carefully to the patient in a careful, humane and sensitive manner caused the physicians to be blinded to the fact that the patient carried the pathognomonic Kayser-Fleischer ring in her cornea. Instead, they treated her with tranquilizers and shunted her to group therapy clinics where she underwent the tortures of the damned.

Question of Evolution

How does this happen to us as we ascend the pinnacle of professional sophistication? Where do we lose touch with the humanity that we plead so clearly in our applications to medical school, to wit: "I've always wanted to be a doctor ever since I was a child because I wanted to take care of people." Even as you sit here, I'm absolutely certain that many of you believe that our curriculum has overstressed the humanities and the elements of social consciousness, depriving you of the opportunity to get a little more science, a little more pragmatism, or another "pearl" while yet in medical school.

Is it the medical education process that is faulty or is the medical school selection process flawed? Or is it just that the process of professionalization invariably leads to behavioral changes among those who have the best intentions in the world? Gradually we become too busy, too impressed with our professional achievements and demands and less impressed with the importance of Ernest, our patient who is seeking help. I believe that most U.S. medical schools have tried, are trying and will continue to try to produce doctors who treat "the whole patient." The medical education literature attests to this. Modern journals carry large numbers of articles on the teaching of humanity, ethics, philosophy and even tenderness to medical students. Certainly this medical school emphasizes "sociomedicine."

But I'm not certain that any medical school, including our own, can succeed in giving you, or teaching you that essence of humanity which is at the ultimate core of a healthy doctor-patient relationship. Teaching new behavioral patterns to young people who enter medical education already mature with well-formed patterns is not an easy task. Furthermore, the hubris and indifference perceived by patients usually reflects contacts with doctors several years beyond formal undergraduate medical education and frequently beyond the three to five years of residency training that follows the M.D. degree (although some residents can be notoriously proud.) So what can be done to influence you at this late stage of your undergraduate career? The fact that in medical education results for a good cause are less than perfect is no reason for not trying, and since the task is complex and difficult, I've elected to address the issue in simple terms.

Creatures of Stature

Let me quote from two persons who in their own way and in different ways sum up what I'd like to leave with you. One was a dramatist, the other a physician. One I've met personally and the other I've met through reading her autobiography. These two people have helped me in approaching patients as much as any course or any text has ever done.

Lorraine Hansbury, the author of *Raisin in the Sun,* wrote in her autobiography, "I think that virtually every human being is dramatically interesting. Not only is he dramatically interesting, he is a creature of stature whoever he is. . . ."[1]

When I first read those phrases as a physician, it struck me like a bolt of lightening. I could not help but think of so many people I have treated in the past about whose lives I knew very little. While their management was technically correct, was it emotionally correct? A contemplation that each life is "dramatically interesting," and each individual "is a creature of stature" added a new dimension to my therapy. There were no dull patients, and no stupid patients; only people with different talents, different abilities and different anxieties. Each patient became unique as I learned to accept each human being as dramatically interesting. Each one has a life that is just as full of complexities as the busiest specialist. It may

be that the drama for them is quite different from anything we physicians know as "dramatically interesting." The drama usually doesn't appear in the written history and physical examination. It may be a concern for food, for paying the rent, for dealing with an alcoholic spouse or an aging and senile parent. It may be the agony of a child gone astray or of a child abused. It may be a divorce, the loss of a job, the failure of a crop, the foreclosure of a loan, the appearance of a serious disease or all of the above. It may be just the inability to cope with the incredible complexities of modern life.

Look at your own education, for example, which I summarized earlier. Despite all that preparation, doctors are subject to every human foible. We crack up; we become disabled; we commit suicide; we sometimes throw up our hands in despair and don't know which way to turn. Keep in mind that the grade school graduate and the high school graduate we see in our office is dealing with the same world external environment as we are. That person is sometimes infinitely more frustrated by it than we are but is less able to verbalize that frustration since it is so poorly understood. Think of that when an inarticulate presentation grates on your nerves. High interest rates mean one thing to bankers, but to our patients, high interest rates may mean that payments on a family car which is absolutely necessary for work and family income take precedence over visits to the doctor and the purchase of vital drugs. Many patients have to deal with choices that the physician is not the least bit aware are being made. Can you think of the anxiety caused to the person who makes a car payment knowing that a member of the family is not getting the right medicine?

This is *not* an appeal for socialized medicine. This is simply to remind you that these dramas exist every day below the surface of whatever your patient will ever tell you and therefore you must understand that virtually every patient, whoever he or she may be, is always beset by more human problems than you can imagine. For one thing you can be sure of, no matter how simple, how uneducated, or even how perverse the patient appears to you, that patient's life is filled with drama and with pathos, with life and with death and with everything you and I experience in life beyond your own wildest dreams.

Behind the demeanor of every patient is a human being who is frightened by illness, beset by many other problems and a person who seeks your help and understanding. All patients are "creatures of stature" and you should never forget that fact. You should also know that every patient, no matter how quiet or simple they seem, has very sensitive antennae pointed in your direction and listening for your reaction, your affect and your attitude towards them. You may not see or otherwise detect the antennae but you can be certain they are there. Therefore, no matter how pressed you are for time or how unimportant you believe patient complaints may be; unless you treat patients with the dignity and humanity they deserve, and exhibit a sensitivity that you understand (even if it is to say "I'm sorry I don't have enough time to give your case thorough consideration today, why don't we try it another time"), you are not practicing complete medicine.

It is so easy to ignore the drama of patient lives and to forget that every patient is important within his own microcosm. It is also easy to forget that a small bit of kindness and understanding goes such a long way towards relieving anxieties that even the patient doesn't know he has. Kindness from a physician is therapeutic. It also allows the patient to open up historical secrets that could easily help in traditional diagnosis and therapy.

A Pithy Phrase

There is a second quote I'd like to leave you with that complements the drama of patient lives. It comes from a Dr. Williams Evans, a crusty Welsh physician who taught cardiology in London for many years and who was a great human being. Professionally Dr. Evans first described alcoholic cardiomyopathy and remained a leading cautionary in the administration of anticoagulants to patients with coronary artery disease. He was a master of the pithy phrase, well illustrated by his simple but rather poignant comment about coumadin: "I do not administer rat poison to my patients." Whenever Dr. Evans had a particular point to make to students, he would order: "Take out a pencil and paper and write this down," and would wait patiently until every person in his audience—residents, visiting physicians or even prime ministers it seemed (he cared for Stanley Baldwin during the 1930s) had submitted to the dictate. At times he would provide the tutees with pencil and paper himself so that they could write down the pearl he had to deliver.

The Evans axiom I give to you now is "Every patient should leave a doctor's office feeling a little bit better." No matter what news the doctor has to give, no matter what the diagnosis, no matter how grim the situation, the patient should leave the doctor's office feeling better. The doctor has the power to do that. You may not realize it, but you do have such power. The patient who comes to the doctor—no matter how sophisticated—comes with a certain amount of fear and dread and the hope that somehow in the gifts that have been given to you through your education, you will be singularly able to prolong their life, to improve their health, to give them aid, and to make them feel better. If that were not the case, no one would come.

"Every patient should leave a doctor's office feeling a little bit better." It is a simple axiom which contains the essence of medical practice and medical humanity. If you keep it in mind you can't go too far wrong in dealing with a patient.

Let me give you a simple illustration: A young resident was treating an asthmatic patient in all the correct ways, at least medically. The patient had intravenous aminophylline, cortisone, epinepherine—everything necessary to relieve the asthmatic symptoms. But the asthma wouldn't go away and while the medication gave some relief the breathlessness always returned. Indeed, the asthma seemed to be worse whenever the resident was present. The resident was very frustrated by this and became angry

because the nurses advised him that the patient's asthma worsened in connection with the resident's visits to the patient. The resident concluded, of course, that the patient was "putting on an act" for the resident so that she could remain in the hospital. The more the doctor's anger waxed, the more the asthma waxed.

When I saw the patient, and this was many years ago, it was apparent that when the resident saw the patient, only hostility and arrogance were transmitted. The resident failed to transmit to the patient that his concern for her was as great as his concern for her illness. He was never able to leave the patient feeling a little better.

The resident and I talked about this together at great length and being a good resident, he listened and agreed to approach the patient with a more sympathetic and understanding view. He resolved that he would not leave the patient after a visit without the patient feeling better.

The results were dramatic. The patient was out of the hospital shortly thereafter and there is at least one physician in this world I know that understands very well the dictum I have given you.

So as you go to begin your medical careers—and all of you will see patients throughout your careers whether or not you are in full-time practice, teaching or research—keep these thoughts in mind. Every patient is dramatically interesting . . . a creature of stature. None should leave your presence not feeling a little bit better. Ernest is very important. ◂

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Daniel K. Bloomfield, M.D. is a professor of medicine and acting head of the department of internal medicine, University of Illinois College of Medicine at Urbana-Champaign. Dr. Bloomfield retired as dean of the University of Illinois College of Medicine at Urbana-Champaign on June 1, 1984, and remains in private practice. A board certified internist, Dr. Bloomfield is a fellow of the American College of Physicians. Dr. Bloomfield's tenure at the University of Illinois included concomitant service as dean of the School of Basic Medical Sciences and dean of the School of Clinical Medicine dating to 1970.

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Reaching For Solutions

Lee A. Daniels (R-Elmhurst) is the Republican leader in the Illinois House of Representatives. As minority leader in the House, he played a major role in negotiations which resulted in passage of the Medical Malpractice Reform Act of 1985. We asked Rep. Daniels for comments on the legislation and the political realities that played a part in its passage.



IMJ: *Your involvement in medical malpractice reform legislation dates to the very beginning of the ISMS effort. What engendered your commitment?*

Rep. Daniels: My initial exposure to malpractice reform began as a freshman representative, when I served on the House Judiciary Committee in 1975 and 1976. That committee heard the reforms proposed by ISMS at that time. The experience caused me to want to work toward an equitable solution.

The current crisis and information I received just rekindled that interest. For instance, rising and uncontrolled medical costs, and skyrocketing insurance costs. Data showing that malpractice insurance premiums add about $200 million annually to health care costs in Illinois.

The physicians brought it home when they talked about how the average award in a malpractice case was set at $15,600 in 1977, while the average award in 1983 had jumped to $132,000. We were told that claims against the Illinois State Medical Inter-Insurance Exchange had increased 163% from 1977 to 1984. The rates for one hospital in my district had jumped 33% from 1983 to 1984. These kinds of figures were furnished to us by the medical society as we went through the legislation. As we looked at them, we realized that serious problems existed.

In my opinion, the practice of defensive medicine also adds millions of dollars to hospital bills—bills which are ultimately paid by consumers. These factors, coupled with evidence that doctors are actually leaving specialized areas of practice because of malpractice insurance costs, worked to bring the issue home to the public at large.

After looking at the overall problem, I had to decide which side of the issue I wanted to come down on, and who I wanted to represent, more or less, in negotiations. Because of the defensive medicine, because of the insurance costs escalation and because of the frivolous lawsuits, I thought the most meritorious side was the side of the physicians and hospitals. That's why I decided to approach the issue from their side in the negotiations. I favored the legislation in its original form and would have supported all of the provisions in there. I am happy to say that we got most of them.

IMJ: *Which elements of the package were most readily accepted?*

Rep. Daniels: Obviously, the caps were the most controversial. The proposal for caps represented a major change in our tort system in

Illinois. It wasn't accepted at this point in time because the votes just weren't there to do it.

Several items were accepted very quickly. I don't think most legislators really had any difficulty with the idea of screening panels. It came down to a question of how to set them up so it wouldn't be challenged and set aside by the courts. I think that by the time we got to the negotiating session, there was some agreement on counterclaims.

Overall, I would say that the elements in the package all tied in together. I presented it as an opportunity to resolve this issue if these items were accepted. I presented them all in one package.

IMJ: *When did you feel that the battle would be resolved and that most of this package would pass?*

Rep. Daniels: I don't know that I actually had that feeling until the governor signed the bill. You've got two chambers to deal with; there's an awful lot of work. I would say that when I sat down in the negotiating session with the governor and the other leaders in my office, I had an idea that we were going to be able to work something out.

The seriousness of the situation prompted legislative response. We looked at the issues and the depth of commitment, and the 4,000 doctors who came to the Capitol on May 22nd. These things spurred the lawmakers to make a decision.

IMJ: *There were sufficient objective facts to persuade people that the bills had merit?*

Rep. Daniels: Coupled with the fact that the doctors rallied in Springfield on May 22nd. That was a very important part of the overall picture. I hope the doctors will continue to come to Springfield to talk to legislators. They can't assume that the battle has been fought and won, because it hasn't. The only time the battle is fought and won is when there is no more malpractice, and all frivolous suits are gone, and nobody's injured. That's not going to happen. That should tell you that there will never be a time when physicians should not be interested in what goes on in Springfield as it relates to health care. They have to pay attention to it.

IMJ: *Many of our members had never been involved in public affairs prior to the Initiative. Many met their legislators and came to Springfield for the first time this spring. How would you suggest that they channel their new energy and interest in government?*

Rep. Daniels: For one thing, they've got to make sure that they are registered to vote. That's very basic. And then they've got to vote. They should vote for legislators who represent their interests. They have a right to do that; it's our system of government. They have a right to know where their legislator stands on issues. And they ought to make sure that the person they're voting for represents their interests in Springfield, whether they be Republican or Democrat. That's what a representative democracy is all about.

When they have a legislator who supports their interests, they ought to support that legislator financially and contribute to his or her campaign fund. That's very easy to do. There's a deductible expense of $200 a year on a joint return. They can send a check to the fundraiser and sponsor a coffee.

The doctors should get to know their legislators so they can pick up the phone and say, "Hi Joe, this is Dr. So and So. I'm interested in this legislation and I'd like you to study it and do your best to support the views of the physicians." It's a very effective legislative strategy. When the time comes for a vote, the legislator knows that the doctor will be calling and tracking on his position.



The only time the battle is fought and won is when there is no more malpractice, and all frivolous suits are gone, and nobody's injured. That's not going to happen.

IMJ: *What you're describing is the classic model of grass-roots involvement.*

Rep. Daniels: Absolutely. And that's very much what's involved here. It's a continuing process. Today's victory is not tomorrow's guarantee. You have to remember that despite the success of the doctors' rally on May 22nd, tomorrow is another day. In the political arena, tomorrow is another vote and tomorrow is another election. We have to run for election and the doctors should be involved in the grass-roots of the campaigns. Because you can bet your life that the plaintiff attorneys are involved in it. The people who oppose legitimate malpractice reform are involved on the other side.

IMJ: *A few elements of the original ISMS malpractice reform proposal, such as caps on non-economic losses, were not passed into law. Do you think the legislature will soon become more amenable to some of these elements? Are they essential to complete the picture?*

Rep. Daniels: Well, caps were a major aspect of the legislation when it was introduced. We have to see how this legislation fits into the overall picture to reduce or hold the line on malpractice awards. If it works, then I think caps will probably be pushed in the background for a while. If it does not, they will be highlighted again.

I think you're going to see a discussion of caps involving not only malpractice cases, but all tort cases. There's a question of whether or not the insurance industry can insure against any type of personal injury award, be it an auto accident, or a malpractice claim, when there are injuries and suit is brought to compensate somebody for these injuries.

Assessment of compensation for personal injury is an age-old issue. How much is a broken arm worth, or a broken leg, or some permanent damage? No amount of money can compensate for permanent damage, whether it's loss of a finger, loss of a leg, or brain damage.

The monetary aspect is really not the issue. You have to consider what's fair compensation and what the person needs to enjoy a standard of living that they would have reasonably expected to enjoy.

The real issue for the future is caps on non-economic losses, which were part of the original ISMS package. We have runaway verdicts right now in Cook County. If you look at the jury verdicts in Cook County and compare them with the rest of the state, you'll find substantial disparity. Does that mean that life is worth less in DuPage County than in Chicago? Of course not.

I am not one who would say that people are not entitled to adequate compensation when there is a legitimate malpractice case. And I think people ought to be compensated quickly and properly. But people have to take into account the impact in terms of malpractice premiums. It's ultimately passed on to the consumer. That's an important part of the overall picture.



No amount of money can compensate for permanent damage, whether it's loss of a finger, loss of a leg, or brain damage. The monetary aspect is really not the issue.

Today, more than ever before, when somebody gets a sore throat, they'll call a doctor. They don't want the sore throat to be cured in four days. They want it cured immediately. If the result is not satisfactory, people immediately think, "Well, why didn't my doctor do something more for me?" When, in fact, certain viruses that may be going around can't be treated with medication.

We expect more from our physicians. We demand more from them and, as a result, they have to engage in defensive medicine. Our hospitals engage in defensive medicine. All the costs are dramatically increased. That translates to higher costs to the consumer.

We need a balancing of our tort system. And that's what the legislature is prescribing.

IMJ: *Do you see a trend toward tort reform in other areas? Have other groups discussed similar packages?*

Rep. Daniels: I see a trend toward that. I don't pretend to have the answers for it. I think that the challenge for legislators today is to find the solutions which protect the pub-

lic at large, and at the same time, recognize the interests of the various factions seeking tort reform. You've heard the old saying that "justice delayed is justice denied." That's very true in all kinds of claims—from malpractice to personal injury. And a seven year delay and backlog of personal injury claims is just too long. A person should be compensated as quickly as possible for loss—particulary when somebody's clearly wrong. Whether we do that through a long, dragged-out trial, or devise some kind of compensation system, it will have to be addressed at some point. Whether that's one year, two years, five years or ten, only time will tell.

IMJ: *Are there specific areas where you expect to see related legislation in this session?*

Rep. Daniels: I don't know if we're going to address it in the 1986 session. I think we'll hope first that the courts will sustain the constitutionality of the legislation, and I believe they will. Then we'll wait for the law to go into effect and see how it operates. There must be recognition that, under the best of circumstances we will still have to continually address the malpractice problem, the product liability problem, the overall tort problem and the overall insurance problem. We now have a crisis in insurance coverage throughout the industry, in all spheres, not just malpractice. We're finding problems in other insurance coverage areas, too, that we're going to have to address.

If you look at the jury verdicts in Cook County and compare them with the rest of the state you'll find substantial disparity. Does that mean that life is worth less in DuPage County than in Chicago? Of course not.

IMJ: *But you could envision an equitable compensation system that would be legislatively feasible? Something that would pass?*

Rep. Daniels: Yes, I would hope so. That's one of the things we're striving to find in balancing everyone's interest. After all, a doctor or any other person who is wrongfully sued has every basis in the world to condemn the tort system. And more so with doctors, because you find that they have a great personal interest in their profession, which seems to come through a lot more than in other professions. Maybe that's because they're dealing with life and death.

In terms of the overall tort system, we have to address everybody's interests. If a doctor is negligent and damages a person, that person who is injured permanently has as strong a claim as anyone else to immediate compensation for their injuries. That's where we have to balance the doctor's interest and the patient's interest. Everyone wants a patient who is wrongfully damaged to recover quickly and properly. On the other hand, if the doctor is wrongfully sued, he may have a claim for injury and damage too. We're trying to address that.

IMJ: *As an attorney, what's your feeling about the integrity of the legislation in the face of court challenges?*

Rep. Daniels: I think it will withstand a court challenge. We will be able to overcome the challenges that have been brought about by people who are coming from a different viewpoint. The defense of this legislation will show it to be constitutional in its final form. I hope that will be accepted by everybody.

IMJ: *Do you have a sense of a response from the legal community?*

Rep. Daniels: For the most part, I think the legal community recognized that the problem existed, and I believe they knew the General Assembly was geared up to act this year—the issue had been before us legislatively for several years already. When that is the case, eventually action is taken.



Lawyers who represent the defendants in medical malpractice cases are pleased with the reforms for the most part. Lawyers on the plaintiffs' side however, were vehemently opposed to the legislation that was presented. For the most part, they were represented by the Illinois Trial Lawyers Association.

IMJ: *You were a key architect of the tax plan that passed in 1983. How do you see the State budget evolving in the next several years? What kind of financial priorities are going to arise?*

Rep. Daniels: On the heels of the recession it became obvious to the General Assembly and to the governor that a tax increase would be needed to meet our revenue commitments. Most of the key players had more or less signed off on some form of permanent tax increase. However, House Republicans put a plan on the table for a temporary

tax increase, and that plan eventually was adopted. In fact this past July the tax came off as promised.

It was our feeling that one, we wanted to avoid a permanent tax increase, and two, we wanted to avoid the situation in which many of our sister states find themselves today: Huge surpluses resulting from permanent tax increases, which lead to increased spending.

In terms of priorities, this year we passed an education reform package that put Illinois at the head of the class in terms of its commitment to education. To pay for it the legislature just passed a cigarette tax with the revenue earmarked to education. I think that is how priorities arise: The public demands a solution to a problem, we make it law, and then we fit it into our spending picture. Frankly, I don't think the general public minds paying for good, sound programs like education, that ultimately benefit their everyday lives.

For the future, I would say we must carefully monitor spending in the next few years, continue to cut waste, so that we can meet our commitments as a state government. Most people don't realize we have a $19.7 billion budget. That represents a tremendous demand by the public for what they perceive to be needed services, so you're talking a lot of money and a lot of commitments.

IMJ: *How would you define the emerging public health issues for the 80s?*

Rep. Daniels: I don't think there is any question that the malpractice crisis has emerged as the number one health issue. It has many other problems associated with it. For example, how can we bring down the cost of furnishing medical services—what more can we do? Does society expect too much of its hospitals and doctors? How can we balance scarce health resources against public demand for service? What is the private sector's responsibility in financing a health care system?

Issues like organ transplants, medical ethics and the dilemma surrounding the medical community with regard to long-term care for terminal patients. All of these issues will reach the legislature in one form or another and they impact the health care system as a whole. They are issues of concern on a nationwide level as well. I expect the health care debate to accelerate in Illinois.

IMJ: *What other important legislative issues do you anticipate in the near future?*

Rep. Daniels: I mentioned earlier the liability insurance crisis that we are going to be facing. That's a very tough subject for local governments and business. My laundry list would include selection of judges, the State Mandates Act, interstate banking, farm aid, education reform, funding of local governments, and whatever comes out of Washington. We expect Washington to cut into the state's revenues a lot more by forcing federal programs down into the states, where we will have to pick them up. Those are all things we'll be tending to in the next year or so.

IMJ: *What do you enjoy about politics? What gave you your start?*

Rep. Daniels: I like the challenges. I enjoy dealing with new issues and problems that present themselves for resolution. The legislative branch provides a unique ability to come to conclusions. At times, it can be a little rough. But you can reach solutions to problems. That's the nice thing about that branch of government.

I was brought up in politics. My grandfather was state's attorney of DuPage County from 1940 until



The legislative branch provides a unique ability to come to conclusions. At times, it can be a little rough. But you can reach solutions to problems.

1952, and he served in the Illinois House from 1956 to 1962. So I started working with the Republican party when I was old enough to walk. I was walking precincts at election time and delivering materials for all of the candidates.

After I had completed law school, Senator Philip decided to run for the Senate and his House seat opened up, so I ran successfully for the House in 1974. That was right after Watergate, and few Republicans were elected to office. I guess you'd say I was a Watergate baby.

IMJ: *You've been House Republican leader for three years now. How does that enhance your ability to find good solutions?*

Rep. Daniels: As the House Republican leader, I'm one of the five top leaders in Illinois, along with the governor, the president of the Senate, the Senate Republican leader, and the speaker of the House. I am able to appoint all House Republicans to their committee posts, which determines the structure of House Republican organization input to each committee. I also am able to shape and develop issues into legislation. The governor's office asks me to select sponsors for administration bills. I would say that, as leader on your side of the aisle, you have a unique opportunity to have a very personal influence on legislation.

Today's victory is not tomorrow's guarantee. You have to remember that despite the success of the doctors' rally on May 22nd, tomorrow is another day. In the political arena, tomorrow is another vote and tomorrow is another election.

Another responsibility is the House Republican Campaign Committee. Our primary goal is to elect Republicans to the House. We think they are much more attentive to problems that are presented in Springfield. In terms of the campaign committee, we'll be engaging in grass-roots campaigns. We hope that we will hear from the doctors throughout the state. For the most part, the Republican legislators were there to assist the doctors when they needed help. We hope the doctors are there to assist us at election time.

IMJ: *What about your own goals?*

Rep. Daniels: I intend to run for re-election in the House. I hope that we'll elect a Republican majority so I can become Speaker of the House. Those are my goals. ◀

EKG

(Continued from page 373)

Answers: 1. B, C, D 2. C

The twelve lead ECG has normal sinus rhythm at a rate of 60 beats per minute with normal PR and QRS intervals. There are significant Q waves in leads II, III, and AVF compatible with an inferior wall myocardial infarction. The QRS axis is leftward at $-50°$ in the limb leads. This left axis deviation is compatible with left anterior hemiblock and this can occur with an inferior infarction. The tall R wave in leads V_1 and V_2 of 0.04 second duration with an upright T wave are the criteria for a true posterior wall infarction. The presence of an inferior infarction and upright T wave in lead V_1 makes this much more likely to be a true posterior infarction than right ventricular hypertrophy. In our experience, the association of left anterior hemiblock and inferior myocardial infarction was associated with significantly more left anterior descending artery disease as well as more diffuse coronary artery disease than inferior infarction with a normal QRS axis.[1] This finding was in addition to right coronary artery disease.

Exertional angina following a myocardial infarction suggests disease in coronary arteries not involved with the infarction. The development of angina in a patient with this ECG represents a second line of evidence suggesting multivessel coronary disease. In fact, the coronary angiogram showed a 95% obstruction in the proximal left anterior descending artery with an 85% obstruction in the left circumflex and a 60% obstruction in the right coronary artery. The patient had triple vessel coronary disease. His left ventricular angiogram showed an area of inferior-base akinesis or scar tissue of the healed myocardial infarction. This combination of left ventricular dysfunction and triple vessel coronary disease made our patient a candidate for aortocoronary bypass surgery. The coronary artery surgery study (CASS) showed an improved seven year survival in patients with triple vessel coronary disease and left ventricular dysfunction manifested by ejection fractions from 34% to 50%.[2] Our patient underwent successful triple aortocoronary bypass surgery and has returned to full-time work.

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ISMS All-Member Conference Recap

Blueprint For Action

Physicians attending the two day ISMS All-Member Conference learned that their intense grass-roots effort had been termed the catalyst prompting the Illinois General Assembly to pass the Medical Malpractice Reform Act of 1985. They learned that an equally intense grass-roots assault would be needed to persuade legislators to place caps on non-economic damage awards in malpractice cases and give physicians the legal right to hold collective discussions with PPOs, HMOs and other alternative delivery mechanisms. Speakers focused on hospital medical staff concerns and responsibilities, media relations and political realities.

Opening the November 2-3 Illinois State Medical Society All-Member Conference in Peoria, ISMS President Dr. Morgan M. Meyer asked physicians to "put their shoulders to the wheel" and become active. "The pressures we face today have never been greater," said Dr. Meyer. "But we are not helpless as a profession. Your Illinois State Medical Society proved in this year's General Assembly that concerted effort can pay off."

Serious Economic Issues

Dr. Alfred J. Clementi, chairman of the ISMS Board of Trustees, said physicians are at a disadvantage when contracting with alternative delivery systems. As individual competitors, said Dr. Clementi, physicians are barred by federal antitrust laws from collectively reviewing and discussing contracts for their services offered by HMOs, PPOs, and other such entities.

The ISMS board chairman reported that ISMS had been unsuccessful in its attempt to pass legislation which would allow collective discussion by physicians in this area. Vowing that the Society would return to Springfield to seek such a law, he called upon physicians to sustain the work of "action teams" formed during the drive for malpractice reform to exert pressure on legislators.

Collective discussion is "the only answer" to dealing with pressures brought about by the alternative delivery system movement, J. Paige Clousson, president of Physician Support Services, Inc., and former director of the American Medical Association's department of negotiations, told the audience. Clousson indicated that, with legal obstacles removed, several mechanisms would be available to assist physicians—including committees formed by ISMS, county medical societies, and hospital medical staffs.

The medical consultant also had advice for physicians to keep in mind as they addressed economic



More than 230 people attended the ISMS All Member Conference, which explored possible strategies to deal with health care issues confronting the medical profession.

issues. It is important, he said, to be sure that the profession operates from a position of patient advocacy rather than self-interest.

James L. Fletcher, a partner in the Chicago law firm of Winston and Strawn, argued that physicians should be able to retain the autonomy of their private practices, but have a mechanism enabling them to come together as needed to review proposed contracts for physician services. He described the proposed law developed by ISMS that was defeated by intense opposition from a coalition representing business, labor, and the insurance industry.

Fletcher explained that the ISMS contracting bill was offered after a U.S. Supreme Court ruling that states may pass laws to allow negotiating not ordinarily permitted under federal anti-trust laws if such activity is carried out under the supervision of the state. The ISMS legislation would allow organized medicine to play a role in discussions with delivery systems. A supervisory role for the state was included in the proposed structure.

Professional Liability Reprise

Following the general session on economic issues, attention turned to the continuing malpractice problem. Physicians heard from Saul J. Morse, ISMS legislative consultant, who reviewed provisions of the law, which took effect August 15.

In recapping physicians' fight for reform, Morse said the May 22 Springfield rally had been "what made it happen." The rally and public education efforts prior to then had made officials at all levels of government realize that this was "a genuine crisis and that physicians were truly concerned," Morse said.

Echoing Morse's comments, Rep. Thomas J. McCracken, Jr. (R-Westmont), who sponsored ISMS malpractice legislation, said it was grassroots involvement by physicians that made the difference. "This wasn't a case of political compromise," said Rep. McCracken, "it was a case of political power."

Morse also discussed the status of the constitutional challenge to the law by plaintiff attorney Leonard Ring, who brought suit within hours of Gov. Thompson's signing of the bill. In a somewhat novel approach, Ring filed a "taxpayer's suit" seeking to bar the state from spending the public funds necessary to publish the new law in the state statute books.

ISMS had filed an *amicus curiae* (friend-of-the-court) brief in the case, and any decision by Cook County Circuit Court Judge Joseph Wosik was expected to be appealed to the Illinois Supreme Court. Morse said that he would anticipate a Supreme Court decision by late spring or early summer. He cautioned physicians that—even if the Supreme Court rules favorably on this case—challenges to the law could be raised "ad infinitum." Nonetheless, he said, Illinois-type reforms are being upheld by courts in other states, and the U.S. Supreme Court had recently refused to consider a challenge to California's $250,000 cap on non-economic awards.

In discussing implementation of the new law, Morse reported that the major issue would be setting up the system of pre-trial screening panels. As provided by the law, the Illinois Supreme Court was developing the rules to govern their operation. The individual circuit court chief judges would implement the rules and maintain rosters of local attorneys, physicians, and judges to participate in panel deliberations.

In his closing remarks for the morning session, Dr. Clementi strongly encouraged physicians to participate in screening panels. He maintained that through utilization review, tissue committees, and other activities, most physicians have become comfortable with judging the activities of their peers. The ISMS board chairman also emphasized the profession's commitment to medical discipline. He reported that nearly 90% of the respondents to a recent physician survey had favored a disciplinary system with the power of law behind it that was speedy, fair, and rehabilitation-oriented.

Dr. Clementi recalled that the action team concept had taken form at last year's conference. He urged physicians to return to their county medical societies and hospital medical staffs to begin work on the next push for malpractice reform. The board chairman predicted a major effort by ISMS during the 1986-87 General Assembly session to gain a tighter statute of limitations and caps on awards for non-economic damages and wrongful death claims.

Nearly 90% of the respondents to a recent physician survey had favored a disciplinary system with the power of law behind it that was speedy, fair, and rehabilitation-oriented.

Another Perspective

CBS news correspondent Fred Graham focused on legal liability in his comments at the conference's Saturday luncheon. An attorney, Graham has covered legal affairs for CBS and the *New York Times*.

School teachers, municipalities, journalists, and even attorneys themselves are concerned about the liability situation, said Graham, who cited the number of attorneys in American society as a major reason for the crisis. Thirty-five years ago, he said, there was one lawyer for every 700 people. Today, that ratio has decreased to 1 in 415, and at the current rate of increase, there will be more than one million lawyers in the U.S. by the end of the century.

"The legal profession has caught the entrepreneurial spirit of the 1980s," Graham said. "Lawyers create, rather than satisfy, the need for their services." Attorney contingency fees also fuel the number of

suits, Graham said, referring to them as "the mainspring of American legal practice."

Graham said he believes that growing signs of revolt are appearing among non-attorneys, and that change in the system will come mostly at the state level. "State legislatures (that were) dominated by lawyers only three years ago, now are bursting forward to do something about the legal system," he said.

Thirty-five years ago, there was one lawyer for every 700 people. Today, that ratio has decreased to 1 in 415, and at the current rate of increase, there will be more than one million lawyers in the U.S. by the end of the century.

Joint Ventures

After the luncheon, the physician audience dispersed to attend several "breakout" sessions on specific issues. Those attending the first session, "Joint Ventures: A Case Study," heard Richard Gustafson tell them that equity, parity, mutual respect, and good data are prerequisites for successful joint ventures between physicians and hospitals.

Gustafson, who is president of Parkside Human Services Corporation, administrator of the Greater Northwest Health Practice Organization, and senior consultant for alternative delivery systems for Parkside Associates, Inc., illustrated his points in the three-year history of his work in a joint venture with Lutheran General Hospital, Park Ridge.

"You have to find a way to build a structure, recognize the history, establish some trust and find some control," he told the group. Explaining that a well structured joint venture could benefit any physician and hospital group, Gustafson stressed the importance of flexibility.

"Position yourself to contract with all sorts of entities and then, if you choose, you can market yourself as a PPO in some markets and as another entity in others," he said. All such proposals must be studied in terms of the contraints of the local community, he added.

Gustafson stressed the importance of solid legal advice from the outset of any such undertaking and the fundamental role of a good data system. A good physician entity, he said, "is a serious administrative unit that manages care and collects data on how it works . . . if you depend on the HMO to supply the data, at the end of your fiscal year, when you want to do your books, you won't be able to get exactly what you want."

Gustafson said he believes that joint ventures can strengthen physician/hospital ties, provide an equitable forum to resolve conflict, help physicians position themselves for change and give small physician groups an optimal opportunity to participate. He recommended that the governing structure provide parity for hospital and physician group representation.

Equity, parity, mutual respect, and good data are prerequisites for successful joint ventures between physicians and hospitals.

"Both parties have concerns," he said. "Both have to recognize that these are legitimate concerns and discuss them openly and honestly . . . then you can have a win/win situation."

Gustafson emphasized that good faith, solid data, thorough legal review and extensive planning were essential. He stressed that time spent on fundamentals always pays off. "Spend the money to do the research, study the market, educate your people and define your purposes," he told the group.

Medical Staff Organization

At a session on "Organizing An Effective Medical Staff," Dr. Donal D. O'Sullivan, an attorney and chairman of the ISMS Medical-Legal Council, discussed the legal status of the medical staff from the staff and the hospital points of view. Dr. O'Sullivan's main contention was that medical staff bylaws are in many cases not sufficient to meet modern demands.

"The bylaws should provide for self-governance, and the medical staff should be able to make autonomous decisions," said Dr. O'Sullivan. He suggested that the medical staff create its bylaws independently and submit them to the board and medical staff. Physicians interested in model bylaws were referred to the "Guide to Hospital Medical Staff Bylaws," and "Legal Considerations of Medical Staff Bylaws," published the Illinois State Medical Society.

Also addressing the session was Dr. Richard E. Thompson, of Thompson, Mohr and Associates of Elmhurst, a consultant to hospital and medical staffs on medical staff organization. Dr. Thompson said that medical staff functions could be described as the "Five Cs"—credentialing, clinical review, continuing medical education, corrective action, and coordinated input into hospital affairs.

"The executive committee should be authorized to act on behalf of the medical staff," Dr. Thompson said. He argued that this would be appropriate, since the executive committee is an elected body. In addition, he said, "a smaller group like the executive committee can be more efficient. The medical staff is sometimes too large and

Medical staff functions could be described as the "Five Cs"—credentialing, clinical review, continuing medical education, corrective action, and coordinated input into hospital affairs.

too busy. The executive committee can collect input from department heads and others to carry out the wishes of the medical staff."

Medical Staff Competency

Another breakout session examined the role of the medical staff in assuring competent medical care. The session was scheduled in response to increased litigation seeking to allow certain practitioners membership on the hospital medical staff, as well as public and governmental concern over highly publicized incidents of poor care, and the perceived inability of health care providers to "police their own."

Dr. J.M. Ingalls, past president of ISMS and a member of the Illinois Hospital Association Board of Trustees, outlined protections available to physicians willing to work in peer review activities to assure quality care. He recapped ISMS' support for an effective disciplinary system with due process for physicians who are subject to disciplinary action. "It is both desirable and possible to assure the competency of the medical staff and to ensure that individual members are treated fairly," said Dr. Ingalls.

Dr. William R. Fifer, president of Clayton, Fifer Associates in Minneapolis, argued that the granting and renewal of medical staff credentials and privileges should be based on actual performance indicators. He cited current issues relating to competency and liability, as well as JCAH standards, to back up his contention.

Dr. Fifer maintained that acceptance of applications and granting of medical staff privileges with little or no verification of past performance had led to dangerous and embarassing incidents of bad care. He recommended that every staff member have a "quality of care" profile for reappointment decisions, shifting the burden of credentialing from subjective personal decisions to an objective data-based system.

Dr. Fifer held that applications for privileges from new staff members should not be accepted for processing unless they include signed recommendation forms from previous hospitals. He suggested that initial observations of new staff members should be functional (*i.e.*, based on sample numbers of procedures) rather than temporal (*i.e.*, based only on a time period of observation).



Breakout sessions examined such specific issues as joint ventures between physicians and hospitals, organizing an effective medical staff and physician involvement in IPAs.

Communication Skills

The medical malpractice, cost containment, and medical discipline issues have pushed the medical profession into the public limelight. In order to help physicians sharpen their public speaking skills and communicate effectively with members of the media, an introductory public speaking workshop was presented in a fourth breakout session.

Participants learned the basics of delivering their messages to varying public audiences and the media. They also gained actual experience in handling tough questions through videotape simulation of on-camera interviews.

"The ego of presentor must make a mental jump to that of listener," said Libby Fischer, of Fischer Hellmann Communications, who conducted the training session. "We need to cast our messages in terms that people will understand—and care about—as patients."

Workshop participants were advised that the chief way to improve their speaking skills was to "get out on the local circuit," speaking regularly to media, community organizations, and business groups. In short, there is no substitute for experience in becoming an effective communicator, Fischer said.

Evaluating Contracts

Alternative delivery systems are a fact of life, and most physicians can expect to face the issue of entering into contracts with PPOs, HMOs, and other such entities. To acquaint physicians with some of the issues that are accompanying the move toward alternate delivery mecha-

nisms, a breakout session examined the new PPO law and outlined the operation of the ISMS office of contractual services. This ISMS service offers Society members a review of contracts offered by organizations interested in contracting for physician services.

Clive Topol, a partner at the law firm of Winston and Strawn, explained that—while not legal advice—contract reviews conducted by ISMS attorneys can help physicians evaluate the provisions of such contracts and make their own decisions about signing them. Reviews are particularly helpful in identifying potential problems, such as those posed by "hold harmless" agreements, prior approval for treatment, or unilateral amendment of a contract by the organization. Other pertinent issues, he said, include contract termination, marketing obligations of the contracting entity, timeliness of payment, utilization review procedures, non-covered services, and elevated standards of care.

IPA Case Studies

During a breakout session on physician involvement in individual practice associations, two former ISMS presidents, Drs. Fred Z. White and Robert P. Johnson, presented discussions of IPA models based upon those operating in their respective areas of Peoria and Springfield.

"Alternate health care systems need to be physician-oriented," Dr. White said. IPAs which are physician-run and reviewed give the physician an opportunity to negotiate for the patients he or she does business with, according to Dr. White. He added that the goal of IPAs was to provide comprehensive, high-quality, cost-effective care to patients.

The basic premise underlying Peoria's Central Illinois IPA (CI-IPA) is to give participating physicians equal responsibility, incentives and risk, Dr. White said. He explained that membership is by invitation only and is probationary for the first year, after which physicians are offered full membership and a share of stock in the corporation.

Under the CI-IPA, "personal care physicians" select the hospital and ancillary services based upon quality, cost, and location. This system encourages physicians to be cost-conscious, said Dr. White, because surpluses and deficits are shared by each participant.

The Foundation for Medical Care of Central Illinois (FMCCI) is sponsored by the Sangamon County Medical Society and serves 11 counties in central Illinois. FMCCI differs from CI-IPA in that it contracts with Blue Cross/Blue Shield of Illinois, which underwrites the plan, according to Dr. Johnson. It's also a much larger group, representing about 95% of the area's physicians.

Again, physicians are able to select their hospital and ancillary organizations to work with. They also are responsible for utilization review and quality control. The third party payor processes claims and provides financial support, said Dr. Johnson.

The essential elements of health care reporting were described as diseases, diagnostics, drugs, and dangers, coupled with prevention, payment, politics, and public health.

ISMIE Network Meets

In a meeting on Saturday afternoon, held in conjunction with the All-Member Conference, ISMIE Network representatives learned that the Exchange had rescinded its policy to offer occurrence coverage only and was expected to switch to exclusive claims-made coverage effective with the policy year commencing July 1, 1986. In announcing the change, ISMIS Board of Directors member Robert C. Hamilton, M.D., explained that reinsurance was no longer available to companies offering occurrence coverage.

Network representatives also learned that a necessary mid-year rate increase would be deferred and incorporated into the next year's premiums.

Physicians have an essential responsibility to assist the media in getting accurate, timely, and understandable information out to patients.

The Profession's Image

What is the public image of medicine today? How do patients learn about health care? What can the medical community do to improve communication skills with those outside the profession? These questions were addressed by two experts in public opinion and health care information during a general session on Sunday morning.

"Being in the public 'fishbowl' is foreign to physicians," Dr. Barry Kaufman, a 10-year veteran of health care reporting for Chicago's WMAQ-TV, told the audience. Yet, he added, the public's appetite for health care news is "voracious." Kaufman asserted that physicians have an essential reponsibility to assist the media in getting accurate, timely, and understandable information out to patients.

"Not putting the pieces of the puzzle together" in health care reporting is perhaps the biggest deficiency in television news today, according to Kaufman. Stories are brief, dramatic and often generate high expectations. They fail to discuss the hidden, important issues

behind the new medical "miracle cures" they promote. In fact, Kaufman queried whether health care reporting actually "sets the stage for litigation" in covering the benefits, but rarely the risks and the costs of new medical technology.

As health care reporting continues to mature, he suggested, the media will get better at finding the real stories—as opposed to the obvious ones. In doing so, they will depend upon and need a wide range of medical input from practicing physicians, in addition to the traditional news sources of university physicians and researchers.

Kaufman urged physicians to get to know their local media and to speak out on important patient issues. The essential elements of health care reporting were described as diseases, diagnostics, drugs, and dangers coupled with prevention, payment, politics, and public health. Health care consumers need and want practical, useful news on these topics, he said.

Robert Teeter, president of Market Opinion Research, a national polling firm, tackled the issue of how physicians can improve public perception of them as a profession. "Demographics have changed," Teeter said, adding that the baby boom, coupled with a dramatic increase in the overall educational level, had produced "a whole new, well-educated class which views issues in a much more sophisticated manner." According to Teeter, this class came of age during the 1960s through the 1980s—an era when cynicism, alienation, and distrust prevailed. As a result, he said, medicine and all other American institutions have a much more difficult task in communicating credibly to their consumers.

Physicians, however, have an edge which helps grab patient attention. Health care issues consistently rank at the very top of opinion survey responses to "what people are most concerned about." And physician trust is still relatively high as compared to other institutions. "That trust factor drops markedly," Teeter noted, "when questions of money, income, or fees arise." He urged doctors to capitalize on the already existing good perceptions of the medical profession and to expand and strengthen communications on issues where credibility may be weak.

"Quality of health care and fair costs are the message consumers are concerned with today," Teeter stressed. "Don't deny that problems exist; treat the problem as one for patients and physicians, rather than just for medicine's ranks."

Politics and the Physician

The remaining portion of Sunday's general session was devoted to a discussion of "Physicians and the Legislature," a look at how political involvement by physicians can bring about health care reform. Moderated by Dr. George T. Wilkins, Jr, chairman of the Illinois State Medical Society Political Action Committee, the session included as panelists Senators Judy Baar Topinka (R-Berwyn) and Greg Zito (D-Melrose Park); Representatives Sam Vinson (R-Clinton) and Jesse White (D-Chicago); and Gary LaPaille, staff member for "Democratic Majority '86," the campaign arm of House Democrats.

While the Republican and Democratic panelists often disagreed, they did concur that physician action on the malpractice issue, culminating with the May 22 rally in Springfield, had been a fine example of effective means to influence the legislative process. Speakers urged the medical community to continue its success by contributing to IMPAC, participating in elections, and communicating with legislators on health care issues.

Predictions on upcoming elections provided the most differences among the panelists. "Republicans have the opportunity in 1986 to take over the state Senate," Sen. Topinka argued. She pointed out that a gain of two seats could

Keys to Build Visibility

Robert Teeter, president of Market Opinion Research, offered four specific suggestions for future effectiveness in communicating health care messages. His points were aimed at maintaining and increasing the positive visibility the medical profession built in Illinois during the medical malpractice reform campaign. Teeter recommended that physicians should:

1. Continue to speak with a united professional voice on health care issues. It is essential that organized medicine's future public issues be firmly grounded in the consensus of Illinois' medical community.
2. Remember their friends. Legislators, media representatives, patients and other interests which supported malpractice reform need the continued interest and input of physicians on a wide variety of health care issues. This means a personal commitment for community, political, and legislative outreach by physicians.
3. Do everything possible to make the malpractice reforms work. Now is not the time to step back from the liability reform scene. Physician participation is critical in volunteering to serve on pre-trial screening panels, as expert witnesses, and in working to assure a strong medical disciplinary system.
4. Take the opportunity to begin planning now for future issues—and how the medical profession's message can be best communicated to the public. Getting a message out—and heard by patients—is a long process. It involves generating initial awareness, building understanding, making believeable arguments, fostering patient concern and involvement, and catalyzing a change in behavior.

accomplish Republican control.

Rep. Vinson maintained that the House of Representatives also could be controlled by Republicans after 1986 if physicians worked to defeat the 17 Democratic House members who voted against the malpractice legislation on a critical vote in the last session. Vinson pointed out that at least three Democrats representing predominantly Republican areas could be vulnerable to campaigns of good Republican candidates.

But Sen. Zito urged physicians to continue working with Democrats as well as Republicans—especially in elections where Democrat incumbents were friends of medicine. LaPaille disputed Vinson's contention about possible Republican control of the House, arguing that the Democrat-favored legislative map would ensure a Democrat/Republican split along the same lines after 1986. "With Ronald Reagan at the top of the ticket in 1984," LaPaille said, "Democrats still won the Illinois House of Representatives overwhelmingly."

Turning their attention to the specifics of campaigning, the panelists then discussed mechanisms for physician involvement. "Volunteers make the difference," said Rep. White. He suggested that physicians host "coffees," walk precincts, and work in campaign headquarters. "Don't sit on the sidelines," he said.

Sen. Topinka pointed out important differences between city voters who usually cast straight party ballots and suburban voters, who are "ticket splitters." "Suburban voters have left the city to get away from being told how to vote," she said. "and like to think of themselves as issue or candidate voters, not partisans." She emphasized that suburban candidates need volunteers much more than city candidates who can rely on patronage workers.

When asked about the most important issue facing the legislature in the next two sessions, almost all agreed that the liability crisis in all lines of insurance would be a major consideration. Other issues mentioned were transportation, education, farming, AIDS, and jobs.

Wrap-Up

In closing the All-Member Conference, Dr. Meyer called on physicians to share the information obtained at the meeting with colleagues who had not been present. He also urged them to keep up their contacts with the media and civic groups regarding malpractice and other problems. "Don't depend upon anyone else to carry our message," he said. "Work together, trust each other, and be united," he said. "It's the only way in which we can continue on the road to solutions." ◀

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MEDICAL NEWS

EUGENE ROGERS, M.D., F.A.C.P., CONTRIBUTING EDITOR

Microangiopathy is responsible for most of the morbidity and mortality in the Type I insulin dependent diabetic, and accelerated macroangiopathy in the Type II non-insulin dependent diabetic. Good control of blood glucose levels may for short periods reverse symptomatologies, but not the clinical nephropathy and retinopathy. Type II diabetics, well controlled, may lower the risks of atherosclerotic changes. Wound healing and the immune responses to superficial infections are improved. (Young, C.W.: *The Am J Med* 79#3B:8-11, 1985)

Extrapulmonary tuberculosis remains an important infectious disease. Within an eleven year study it accounted for 37% of all new cases of active tuberculosis at a 522-bed community hospital. Most common sites were genitourinary, lymphatic and respiratory other than lung tissue. The tuberculin skin test was positive in 31 of 34 cases. Chest x-rays demonstrated abnormalities in 25 of 38 cases. Presenting symptoms were protean, resulting in delays between onset of symptoms and diagnosis. Suggestive of this diagnosis were foreign birth, prior history of or exposure to tuberculosis, constitutional symptoms, febrile course and anemia. (Weir, M.R., Thornton, G.F.: *The Am J Med* 79#4:467-478, 1985)

Pregnancy increases the risk of focal ischemic cerebrovascular events to about 13 times the expected rate outside of pregnancy. Arterial occlusions tend to occur during the second and third trimester of pregnancy and during the first week after delivery. Venous occlusions tend to occur one to four weeks after delivery. Arterial pathologies are treated on the basis of the lesions, and, when this is not possible, treatment categories are based on the temporal profile of the focal deficit. (Wiebers, D.O.: *Arch Neurol* 42#11:1106-13, 1985)

The Council on Scientific Affairs reports on the studies of saccharin on the incidence of bladder cancer. The incidence of bladder tumors was significantly greater in second generation male rats. This may be a species and organ effect. The AMA committee concludes that saccharin remain available until a stronger carcinogenic effect is proven or an alternative nutritive or non-nutritive sweetener becomes available. (*JAMA* 254#18,2622-2624, 1985)

The fluoride content of 1mgm/liter of drinking water significantly reduced the incidence of femoral neck fractures when compared to geographic locations with insignificant fluoride content. Two Finnish towns were compared as to bone fragility and fluoride content in the drinking water. Fluoridation has reduced dental caries, bone fragility and osteoporosis. In the population over age 50 with femoral neck fractures, 77% were women. The difference between fluoridation and non-fluoridation was most pronounced after the age of 60 in women, and between 50-59 years of age in men. (Simonen, O., Laitinen, O.: *The Lancet* 8452#2:432-3, 1985)

Urinary incontinence is a significant problem in the elderly. It prevails in 50% of institutionalized cases, and 1.6% of the elderly living in the community. Biofeedback of bladder pressure, abdominal pressure, and external anal sphincter activity were used to teach improved bladder and sphincter control. Behavioral methods of habit training to increase the voiding interval and relaxation training to cope with urgency were used. In 39 elderly patients, 19 had stress incontinence, 12 detrusor motor instability, and eight urge incontinence. After 3.5 training sessions, improvements were noted ranging from 82% for the stress incontinent group to 94% with urge incontinence. (Burgio, K.L., *et al.: Ann Intern Med* 103#4:507-15, 1985)

More than 15% of individuals 85 or older are demented; half of these may be Alzheimer's disease. Pathologic studies appear to indicate degenerative changes in the basal forebrain near Broca, the septal nucleus, and the basal nucleus of Meynert. Neurofibrillary tangles and senile plaques surround an amyloid core. These degenerative changes reduce the cortical acetylcholine levels and produce the characteristic memory deficits. The Positron Emission Tomography seems so far to be one of the best diagnostic procedures for indicating a temporoparietal hypometabolism. (Jagust, W.J., Friedland, R.P.: *VA Practitioner* 2#9:55-66, 1985)

The rapid sequence intravenous pyelogram continues to be the preferred non-invasive test for screening cases for renovascular hypertension. Renovascular hypertension is responsible for approximately one percent of all cases of hypertension. The authors reviewed the literature and results which compared renal digital-subtraction angiography and IVP. A delay in the calyceal appearance time in the IVP with films taken at one minute intervals between 1-5 minutes is required for accurate interpretation. (Havey, R.J. *et al*, *JAMA* 254#3:388-93, 1985) ◀

AAMA 29th Annual Convention

The 29th Annual Convention of the American Association of Medical Assistants (AAMA) was held September 30 through October 4, in Lexington, Kentucky. Continuing education workshops, and House of Delegates sessions covered a variety of topics.

Speaker of the House Ann Jordana, RT, CMA-AC, convened the House of Delegates sessions on Monday, September 30 in the Lexington Center East Exhibit Hall. Patricia Bates, CMA, president of the Ontario Society of Medical Secretaries, addressed the House on Monday. Mrs. Betty Szewczyk, treasurer of the AMA Auxiliary, addressed the House on Wednesday. A total of 122 delegates were credentialed in both sessions; registration was 622.

Jo Estrada, RN, CMA-AC (Texas) was elected vice-president. Trustees elected were Juanita Blocker, LPN, CMA-C (Alabama); Ann Ledger, CMA-A (Connecticut); Barbara Parker, CMA-AC (Washington); and Ryan Teel, CMA-A (Washington, D.C.). Other nominees were Lani Dukat, CST, CMA-C (Missouri); Millicent Grant, CMA-A (Colorado); and Maxine Johnson, CMA-A (Pennsylvania). Nominating Committee members elected were Sheila Basilisco, CMA (Michigan); Julianna Drumheller, CMA (Virginia); Sharon Vance, CMA-A (Georgia); and Mabel Welch, CMA-CP (Connecticut).

During the second session President Ivy Reade, CMA-AC, announced that the 1986 regional conferences will be held in Albuquerque, Seattle, Philadelphia, Minneapolis and Nashville. She emphasized that recruitment and retention of members is ultimately the responsibility of the chapter and stressed the importance of defining medical assistants according to their duties instead of in terms of their employers. Ina Yenerich, RT, CMA-AC, executive director, announced that the 1987 regional conferences will be held in San Antonio, Orlando, Omaha, Washington D.C. and Salt Lake City, and the 1988 regionals in Boise, Phoenix, New Orleans, Indianapolis and Baltimore.

The chairman of the Certifying Board reported that the goal of stabilization of the certification fund has been met and that further growth is expected. This permitted the certifying board to decrease the member fee for the certification examination.

The chairman of the Continuing Education Board announced that 1166 CEU programs have been approved during the past 12 months. She credited publication of the Program Director's Handbook with influencing the quality of the programs.

Vice-Speaker Betty DeLong presided over reports of the Reference Committee and Board Reports. The committee and board reports were filed with the recommendation that a position statement advocating credentialing of medical assistants through certification, with mandatory revalidation, be developed, and a verification record of certified medical assistants be maintained by AAMA.

The proposed change in Article VIII-Officers and Trustees and their Qualifications, Section 3, recommending removal of certification requirements for national office, was defeated.

Resolution 85-1, Child Abuse Prevention, was adopted as amended, as was *Resolution 85-2,* Respect the Living Will. *Resolution 85-4,* introduced by the Ohio State Society, regarding the continuation of an Annual Meeting of AAMA, was defeated. *Resolution 85-5* was adopted as amended to read: "the Annual Meeting format continue to be a convention of business and education, held in various locations of the country, as in the past, effective in 1988." *Resolutions 85-6* and *85-8,* calling for collection of all dues by the local chapters, were defeated. There will be no local collection of dues. *Resolutions 85-7* and *85-9,* dealing with standardization of dues, was defeated. *Resolution 85-10* regarding a reduction in national dues, was defeated. *Resolution 85-11* which resolved that "the dues increase based on the CPI be suspended for 1987," was adopted. *Resolution 85-12* which resolved to maintain tri-level membership structure of AAMA was adopted.

The House also authorized formation of an ad hoc committee to study plans for regional conferences with an annual meeting in Chicago.

Information regarding the Illinois Society and/or medical assisting can be obtained from Ehlma Garcia, CMA, EMT-A, president, Illinois Society, Robin Bluestein, CMA-C, Co-Chairman, Public Relation Committee, or Catherine M. Hill, CMA, Co-Chairman, Public Relations Committee. ◂

PHYSICIAN RECRUITMENT PROGRAM

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602.

ALTON:
Population 38,000. Opening a new multimodality diagnostic and treatment center in December, 1985. State-of-the-art equipment includes magnetic resonance, computed tomography, linear accelerator, extensive cardiac studies equipment, chemotherapy facilities, as well as several suites available for private practice physicians. We also plan to have a walk-in outpatient clinic, outpatient surgical center, and pharmacy within the clinic. We are especially interested in physicians practicing in neurology, internal medicine, oncology, orthopedics, pediatrics, cardiology, pathology, urology, gastroenterology, radiation therapy, general surgery, OB/GYN surgery, family practice, and neurosurgery. Available immediately. Contact: Bruce Vest, M.D. or Kimberly Eizember, Doctors Clinic, P.O. Box 617, Alton 62002, (618) 474-7850. (1)

CARBONDALE:
Multi-specialty group needs the following physicians—allergist, pulmonologist, otolaryngologist and orthopedist. Contact: Wayne Given, 2601 West Main Street, Carbondale 62901, (618) 549-5361. (12)

GLEN ELLYN:
Full or part-time radiologist—Position in 60-physician, multispecialty, outpatient facility for radiologist. Facilities include fluoroscopy, tomography, mammography, diagnostic ultrasound, plus general radiology. Salaried position with excellent fringes, excellent workload and hours in comparison with hospital setting, plus the ability to work with a quality leading group in a pleasant suburban environment. Send CV to: Glen Ellyn Clinic, 454 Pennsylvania Avenue, Glen Ellyn 60137. (12)

GRAYVILLE:
On Interstate 64; Population 3,000; 65,000 medical market area. Modern, completely furnished medical-dental clinic facility, 20-minutes from two modern hospitals. Steady economy—oil, light manufacturing, coal mining, power generating, agriculture and service industries. Contact: C.W. Wilson, 610 North Court Street, Grayville 62844, (618) 375-6341. (1)

LINCOLN:
Population 18,000. Serving a county-wide area of 40,000. Located on Interstate 55, 200 miles south of Chicago and 100 miles north of St. Louis. Average 30 miles from Springfield, Decatur, Peoria and Bloomington. Medical group looking for OB/GYN, orthopaedics, family practice and emergency physicians. Contact: Mary Richter, Abraham Lincoln Medical Group, S.C., 311 8th Street, Lincoln 62656. (1)

MONMOUTH:
Internist or family practitioner to join a practice in a small town. Terms negotiable. Please send curriculum to P.O. Box 183, Monmouth 61462. (12)

GUIDE TO CONTINUING MEDICAL EDUCATION

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, Twenty North Michigan Avenue, Suite 700, Chicago Illinois 60602, (312) 236-6110.

Items for this calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues, depending upon the number of listings received. Only courses meeting in Illinois or adjacent states and/or sponsored by an Illinois organization, if meeting outside the state, will be published. Please call or write ICCME and request a "Calendar Listing Form" if you are interested in publicizing your upcoming meeting in this calendar.

JANUARY

Allergy
Contact Dermatitis and Atopic Eczema
For: Interested physicians. Lecture, January 20 (6:00 p.m. cocktails and dinner; 8:00 p.m. meeting) Chicago. **Sponsor:** The Illinois Society of Allergy and Clinical Immunology, 800 E. Northwest Hwy., Suite 101, Mt. Prospect, IL 60056. **Fee:** $15. **Reg. Limit:** None. **Credit:** Category 1: 1 hour. **Contact:** Diane Kubis. **Phone:** (312) 255-1024.

Family Practice
Introductory Course to Osteopathy in the Cranial Field
Course, January 7-11, 8:30 a.m.-6:30 p.m., Chicago O'Hare Marriott Hotel, Chicago, IL. **Sponsors:** Chicago College of Osteopathic Medicine and Sutherland Cranial Teaching Foundation. **Fee:** $675. (send fee to: Sutherland Cranial Teaching Foundation, 1140 W. 8th St., Meridian, Idaho 53642) **Reg. Limit:** 44. **Credit:** Category 1A-AOA: 40 hours. **Contact:** Richard A. Feely, D.O. **Phone:** (312) 266-8565.

Pathology
Joint Meeting with American Association of Clinical Chemists
For: Pathologists and clinical chemists. Symposium, January 13, 7:00 p.m., Drake Hotel, Chicago. **Sponsors:** Chicago Pathology Society and Michael Reese Hospital. **Fee:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall Short, M.D., Dept. of Pathology, Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644.

Surgery
Specialty Review in Thoracic Surgery
For: Thoracic surgeons, general and cardiovascular surgeons. January 6-11. **Sponsor:** Cook County Graduate School of Medicine. **Fee:** $670. **Credit:** Category 1: 47 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Review Course in Neurological Surgery
For: Neurologists, neurosurgeons. Lecture, January 31-February 9. **Sponsor:** Cook County Graduate School of Medicine. **Fee:** $840. **Credit:** Category 1: 105 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (312) 633-2600.

Neurology/Emergency Medicine
Medical Seminar at Sea (South Pacific Cruise)
For: Physicians. January 15-29, 1986, Symposium-Cruise. **Sponsor:** Southern Illinois University School of Medicine. **Fee:** $500. **Credit:** Category 1. **Contact:** Charles E. Osborne, Ed.D., Assistant Dean for CME. **Phone:** (217) 782-7711.

OB/GYN
Osteoporosis Symposium
For: Physicians. **Date:** To be determined. **Sponsor:** Southern Illinois University School of Medicine, Continuing Medical Education, P.O. Box 3926, Springfield, IL 62708. **Credit:** Category I. **Contact:** Charles E. Osborne, Ed.D., Assistant Dean for CME. **Phone:** (217) 782-7711.

Hematology
Recent Advances, Diagnosis and Treatment of Common Hematology
For: Family practitioners and internists. Lecture, January 18, 8:00 a.m.-12:30 p.m., Urbana, IL. **Sponsors:** Carle Foundation Hospital, 611 W. Park Street, Urbana, IL 61801; and University of Illinois College of Medicine, Urbana-Champaign. **Fee:** $40. **Reg. Limit:** None. **Credit:** Category 1: 3.5 hours. **Contact:** Lisa K. Staley. **Phone:** (217) 337-3022.

FEBRUARY

Allergy/Clinical Immunology
Case Presentations
February 23, 8:30 a.m., Holiday Inn City Centre, Chicago. **Sponsor:** The Illinois Society of Allergy and Clinical Immunology, 800 E. Northwest Hwy., Suite 101, Mt. Prospect, IL 60056. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: 4½ hrs. **Contact:** Diane Kubis. **Phone:** (312) 255-1024.

OB/GYN/Family/Emergency Medicine
Medical Seminar at Sea (Caribbean Cruise)
For: Physicians. February 7-23. **Sponsor:** Southern Illinois University School of Medicine. **Fee:** $600. **Credit:** Category 1: 60 hours. **Contact:** Charles Osborne, Ed.D., Assistant Dean for CME. **Phone:** (217) 782-7711.

Nutrition
Clinical Nutrition in Office Practice
For: Family practitioners, internists, pediatricians, nurse practitioners and dieticians. Lecture/Workshops, February 6, Urbana, IL. **Sponsors:** Carle Clinic Association/Carle Foundation Hospital and University of Illinois College of Medicine, Urbana-Champaign. **Fee:** $40. **Reg. Limit:** 80. **Credit:** Category 1: 6 hours; AAFP: 6 hours. **Contact:** Lisa K. Staley. **Phone:** (217) 337-3022.

Perinatal Medicine
4th Annual Meeting of Perinatal Association of Illinois
February 6, 12:45-4:15; February 7, 8:30-3:45; February 8, 8:30-12:00, Schaumburg, IL. **Sponsor:** University of Illinois College of Medicine. **Fee:** $95 (members); $125 (nonmembers). **Credit:** Category 1: 9 hours. **Contact:** Bruce A. Work, Jr., M.D. **Phone:** (312) 996-7430.

Gynecology
Urinary Problems in the Practice of Gynecology
For: Gynecologists. Symposium, February 8, Holiday Plaza Complex—Matteson, IL. **Sponsor:** University of Chicago, 5841 S. Maryland, Chicago, IL 60627. **Fee:** $25. **Reg. Limit:** None. **Credit:** Category 1: 3 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Pediatrics
Instructional Workshop on the Adolescent Pelvic Exam
For: Pediatricians. Workshop, February 8 and 22, noon. **Sponsor:** The University of Chicago, 5841 S. Maryland, Chicago, IL 60627. **Fee:** $25. **Reg. Limit:** 20. **Credit:** Category 1: 3 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Family Medicine
Advances in Family Medicine
For: Physicians. February 17-21, Chicago, IL. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago, IL 60612. **Fee:** $500. **Reg. Limit:** 90. **Credit:** Category 1: 38 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800)621-4649 in Illinois; (800) 621-4651 outside Illinois.

Surgery
Specialty Review in General Surgery Part II
For: General and specializing surgeons. Lecture, February 17-28. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood Street, Chicago, IL 60612. **Fee:** $840. **Reg. Limit:** None. **Credit:** Category 1: 103 hours. **Contact:** Robert J. Baker, M.D. **Phone:** (800) 621-4649 in Illinois; (800) 621-4651 outside Illinois.

Emergency Medicine
Winter Symposium
For: Emergency physicians, emergency nurses, and paramedics. Symposium, February 21-23, Lake Geneva, WI. **Sponsor:** Illinois Chapter of the American College of Emergency Physicians, 1645 Des Plaines Avenue, Suite 16, Des Plaines, IL 60018. **Fee:** $100-200. **Reg. Limit:** None. **Credit:** Category 1: 10 hours. **Contact:** Jeannine Helms. **Phone:** (312) 298-1970.

MARCH

Oncology
Fourth Annual Oncology Symposium
For: Physicians. **Date:** To be determined, Springfield, IL. **Sponsor:** Southern Illinois University School of Medicine, Box 3926, Springfield, IL 62708. **Credit:** Category 1: Hours to be determined. **Contact:** Charles E. Osborne, Ed.D. **Phone:** (217) 782-7711.

Otolaryngology
Decisions in Diagnosis and Management of Nasal and Sinus Disease
For: Otolaryngologists. Course, March 23-28, Vail, CO. **Sponsor:** The University of Chicago, 5841 S. Maryland, Chicago, IL 60637. **Fee:** $250. **Reg. Limit:** 50. **Credit:** Category 1: 22 hours. **Contact:** Marlene Goldberg. **Phone:** (312) 962-1056.

Cardio-Disease/Physics/Medicine
Medical Seminar at Sea (Caribbean Cruise)
For: Physicians. **Sponsor:** Southern Illinois University School of Medicine. **Fee:** $400. **Credit:** Category 1: 36 hours. **Contact:** Charles E. Osborne, Ed.D. **Phone:** (217) 782-7711.

Neurology
Neurology Symposium
For: Physicians. **Date:** March 21. **Sponsor:** Southern Illinois University School of Medicine, Box 3926, Springfield, IL 62708. **Fee:** None. **Credit:** Category 1: 9 hours. **Contact:** Charles Osborne, Ed.D. **Phone:** (217) 782-7711.

Pathology
Current Concepts on Thyroid Tumor Pathology
For Pathologists. March 17, 7:00 p.m., Drake Hotel, Chicago, IL. **Sponsor:** Chicago Pathology Society and Michael Reese Hospital and Medical Center. **Fee:** None. **Reg. Limit:** None. **Credit:** Category 1: 2 hours. **Contact:** Marshall Short, M.D., Dept. of Pathology, Loretto Hospital, 645 S. Central Ave., Chicago, IL 60644.

Psychiatry
Comprehensive Psychiatry Review, Part I
For: Psychiatrists. March 17-22, **Sponsor:** The University of Chicago, 5841 S. Maryland, Chicago, IL 60637. **Fee:** $500. **Reg. Limit:** None. **Credit:** Category 1: 42 hours. **Contact:** Mary Ann Dillon. **Phone:** (312) 962-1056.

Pulmonary Medicine
Symposium on Chronic Obstructive Pulmonary Disease
For: Physicians and allied health personnel. Conference, March 6-7, Madison, WI. **Sponsor:** University of Wisconsin-CME, 465 WARF Bldg, 610 Walnut Street, Madison, WI 53705. **Fee:** To be determined. **Reg. Limit:** None. **Credit:** Category 1: Approx. 14 hours; University of Wisconsin CEUs: Approx. 14 hrs. **Contact:** Sarah Aslakson. **Phone:** (608) 263-2856.

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